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# Senate

The Senate met at 9:15 a.m. and was called to order by the Honorable HERB KOHL, a Senator from the State of Wisconsin.

## PRAYER

The Chaplain, Dr. Lloyd John Ogilvie, offered the following prayer:

Thank You, dear Father, for infusing Your nature in the Senators You have called to lead our beloved Nation. You have reproduced in them Your concern and caring for the health and healing of all of our people. Thank You for Your compassion expressed in the legislation for patient protection in America.

The Senators may differ on aspects of the implementation of this concern but are one in seeking unity on what is best for citizens across our land. Be with the Senators today as all aspects of this crucial legislation are focused and voted upon. Thank You for the managers on both sides of the aisle who have worked so long and tirelessly to review all possibilities for the best potential for all Americans.

Now as the Senators seek to complete debate and take conclusive votes, may they sense the unity of a common concern for a crucial cause of caring for our people. Place Your hand upon their shoulders and remind them that You are the magnetic center who draws them to unity for the welfare of our Nation. You are the healing power of the world who uses the medical professions to heal. Help the Senators to complete legislation that will assure the best care for the most people.

You, dear God, are our Lord and Saviour. Amen.

## PLEDGE OF ALLEGIANCE

The Honorable HARRY REID, a Senator from the State of Nevada, led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

## APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
*Washington, DC, June 28, 2001.*

*To the Senate:*

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable HERB KOHL, a Senator from the State of Wisconsin, to perform the duties of the Chair.

ROBERT C. BYRD,
*President pro tempore.*

Mr. KOHL thereupon assumed the chair as Acting President pro tempore.

## RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

## BIPARTISAN PATIENT PROTECTION ACT

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will now resume consideration of S. 1052, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 1052) to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage.

Pending:

Thompson amendment No. 819, to require the exhaustion of administrative remedies before a claimant goes to court.

Collins amendment No. 826, to modify provisions relating to preemption and State flexibility.

Breaux amendment No. 830, to modify provisions relating to the standard with respect to the continued applicability of State law.

### RECOGNITION OF THE ACTING MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The Senator from Nevada is recognized.

Mr. REID. Mr. President, I ask that the time I use not be charged against either side.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

### SCHEDULE

Mr. REID. Mr. President, we will resume consideration of the Patients' Bill of Rights. We are going to have a vote at approximately 10 to 10. We have a unanimous-consent agreement in effect that will take us throughout the early afternoon, with votes scheduled throughout that period of time. We expect votes all evening. The leader would very much like to finish this bill today. Certainly the end is in sight. If not, we will work through the night—into the night, not through the night—we will come back tomorrow, and hopefully we don't have to come back Saturday.

What the leader has said is that we are going to complete this legislation. We are going to complete the legislation, plus the supplemental appropriations bill before we go home.

He said he would work Saturday, Sunday, Monday, and Tuesday and Wednesday, the 4th—take that off—and come back after that to complete our work. We are cooperating and doing our very best to meet the requests of Senators BYRD and STEVENS. Their last unanimous consent request has been cleared on this side as far as the filing of amendments. We applaud the four managers who have been working on this bill. We look forward to continuing to work today.

### AMENDMENT NO. 826

The ACTING PRESIDENT pro tempore. Under the previous order, there will now be 30 minutes for debate to be equally divided between the Senator

from Maine, Ms. COLLINS, and the Senator from Louisiana, Mr. BREAUX, prior to a vote on or in relation to the Collins amendment No. 826.

Who yields time? The Senator from Maine.

Ms. COLLINS. Mr. President, I ask unanimous consent that the Senator from Virginia, Mr. ALLEN, be added as a cosponsor of the Collins-Nelson amendment.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

Ms. COLLINS. I yield 6 minutes to the Senator from Kansas, Mr. ROBERTS.

The ACTING PRESIDENT pro tempore. The Senator from Kansas is recognized.

Mr. ROBERTS. Mr. President, here is the issue: The ability of States to determine what is best for themselves. That is the issue. Sure, the issue is the Patients' Bill of Rights. But if Kansas or Nebraska or Maine or Massachusetts or Louisiana or Connecticut—as I look at Members in the Chamber—have an effective patient protection system that is working, why impose new Federal regulations that will force them to overhaul the system they have in place?

The Collins-Nelson-Roberts, and others, amendment would simply give the State of Kansas and other States the flexibility to provide patient protection required under this bill in a way that best fits each State. For example, last year in Kansas we implemented a new law that assists patients who get into a dispute with their insurance company over the refusal to pay for medical procedures. It is a long process, but the independent reviewer will make a decision and reply within 30 business days after an appeal procedure.

According to Kathleen Sebelius, our very good Kansas State Department of Insurance Commissioner, there were 22 cases that were closed last year; 12 decided in favor of the HMO and 10 overturned the decision made by the HMO. Now that more Kansans are aware of their ability to receive this external appeal and receive independent review, more cases have been filed with the Kansas Insurance Department. Simply put, our State commissioner, Kathleen Sebelius, and the Kansas State Department of Insurance are doing a good job looking out for the best interests of Kansans covered by HMOs.

So the question is, Why does the Federal Government need to tell our State we have to completely scrap what we are doing and put into place a Federal layer of new Washington-knows-best requirements? How good is this really for families in Kansas, or your States' families? In fact, Kansas has a large number of patient protections that have been in place for years, and the list is impressive. The list includes a comprehensive bill of rights, the internal and external appeals I have already described, consumer grievance procedures, emergency room services, OB/GYN access, prompt payment, continuity of care, a ban on gag clauses and financial incentives, screening and breast reconstruction, prostate cancer screening, maternity stay, drug and alcohol abuse treatment, standing referral, and the list goes on and on and on.

Under the bill we are debating today, many of these effective consumer protections Kansas has in place will have to be thrown out and we will have to start all over.

Our Kansas State Insurance Commissioner, Kathleen Sebelius, also serves as the president of the National Association of Insurance Commissioners. Kathleen has written a letter that clearly lays out the devastating effects the Washington one-size-fits-all plan will have on State insurance markets, and she warns—listen to this, colleagues—that this is going to be administered by an outfit called the Center for Medicare and Medicaid Services. It used to be called HCFA. If you really want to turn over your state regulations to HCFA, that is another issue that we can talk about for at least an hour or two. The commissioner stated in her letter:

> The proposed patient protection bills are far more complicated than the Health Insurance Portability and Accountability Act, or HIPAA, and will require considerable oversight. To resolve these issues, the National Association of Insurance Commissioners urges Congress to include in any patient protection legislation provisions that would preserve State laws and enforcement procedures, such as internal and external review processes. Failure to maintain State authority in this area could lead to implementation of regulations that are inconsistent with the needs of consumers in a State and that are not enforced effectively.

I think she nailed it right on the head. I am an original cosponsor of the Collins-Nelson amendment because it would allow States to do what they are already doing well. If these standards are not met, only then would the Federal Government come in and impose its standards, and the State would then be required to meet a higher standard in order to be made eligible for the Patient Quality Enhancement Grant Program. Other amendments will have a stick; this is a carrot. I prefer a carrot; other Senators may prefer a stick.

Let me just say, in summing up, can any other Member of this body honestly tell me what is in this bill is better than what the State of Kansas already has in terms of patient protection? Do you know better than our commissioner, Kathleen Sebelius, or Governor Graves, and the Kansas State Legislature? The answer is no.

My colleagues, support this amendment and give States a chance to apply the standards they have currently in place, that are working. The external and internal appeals process is working. Don't make us reinvent the Federal wheel.

I thank the Chair and my colleagues.

The ACTING PRESIDENT pro tempore. Who yields time?

Mr. BREAUX. I yield myself 5 minutes.

Mr. President, I rise in strong support of the so-called Breaux-Jeffords compromise amendment. We are dealing with a question of how are we going to allow the States to continue to operate their own patient protection bills that many of them have already instituted. My own State of Louisiana has passed over 35 different patients' bills of rights guarantees, and they are working fairly well. I think my colleague, Senator JEFFORDS, wants to continue to allow those States to have their State plans in effect when they are substantially complying to what we are trying to do here on a national level.

As Senator KENNEDY said last night, if you had the Collins amendment, there would be no guarantee that States would have a Patients' Bill of Rights. They would not have to do anything if they so chose. A State could say they are not interested in guaranteeing patients within their borders any rights at all, period. We don't think it is the right thing to do. We are not doing it. The only thing that they would suffer, if they decided to take that approach under the Collins-Nelson amendment, is that they would lose grant money that is being authorized in this legislation.

Well, I think that is unfortunate in the sense that we are talking about a national program to guarantee patients the rights they should have under this legislation. I think there is strong agreement nationwide that there is a need to have some kind of a national guarantee that covers all Americans, not just some Americans, not just a few Americans, not just a handful of Americans, but all Americans, in dealing with their health insurance program.

Our compromise amendment does accomplish that goal, and it does it in a way that gives the maximum ability of the States to do what they think is necessary in crafting their Patients' Bill of Rights. The language that we have put forth says that State plans would not be superseded. They will continue to operate as they do today, if they substantially comply with the patient protection requirements that we are instituting on a national level for all Americans.

That doesn't mean their plan has to be exactly the same as the Federal requirements. It has to substantially comply. That is a legal term used in Congress on many other occasions. On the SCHIP program for providing insurance to children, which we have enthusiastically supported, the requirement is that a State can run their own program if it substantially complies with the Federal requirements for all Americans that were instituted by this Congress.

On the Medicare Program, folks here in Washington understand how to apply that terminology.

It is working. My State of Louisiana runs its own plan. I am very confident that my State of Louisiana will continue to run the plan we have in place

right now under the Breaux amendment because it clearly would, in my opinion, substantially comply with what we are talking about here.

We have a definition of what ''substantially comply'' means by saying a State law would have the same or similar features as the patient protection requirements and would have a similar effect. That is not an unbearable standard at all. It does not have to be exactly. It just has to have the same or similar features.

They can design those rights on States that will be tailored to the needs of that particular State, and the only requirement is that it have the same or similar features. That is not too strong a guideline to the States or a requirement on behalf of the States. I think it can work. Most of the States, if not every single State, that have adopted a Patients' Bill of Rights will find their plans in their respective States will stay intact and will still be the State Patients' Bill of Rights under this legislation.

If a State decides for some reason they do not care, they are not going to do anything, there should be the ability for us to make sure all Americans are guaranteed the rights we are talking about today; that they are enforceable; there is an opportunity to go to court to enforce them; and that there is an appeals process when they are being abused.

This is what the Breaux-Jeffords amendment will allow. That is why it is a realistic compromise compared to the amendment of my good friends, Senator NELSON and Senator COLLINS, with whom I have worked on many occasions and will continue to do so in areas such as health. They are trying to do the right thing. Their amendment will allow some States to do nothing. Potentially thousands of Americans will not have any coverage whatsoever if that is the decision of the State.

We are writing legislation for all Americans, and I suggest the Breaux-Jeffords bill is a proper compromise that can bring this about.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator's time has expired.

The Senator from Maine is recognized.

Ms. COLLINS. Mr. President, how much time is remaining on our side?

The ACTING PRESIDENT pro tempore. Nine minutes.

Ms. COLLINS. I yield 5 minutes to the Senator from Nebraska.

The ACTING PRESIDENT pro tempore. The Senator from Nebraska is recognized for 5 minutes.

Mr. NELSON of Nebraska. I thank Senator COLLINS for her strong support for this amendment, and I commend my colleague, Senator BREAUX from Louisiana, for his strong support and consistent efforts to find a compromise.

Certainly, the effort is an improvement over where we had been. One area I want to point out I disagree with my friend from Louisiana is his suggestion that maybe the States will not do anything. If you take a look at the charts that Senator COLLINS and I have up, when you look at all the checks, I suggest the States have been doing something and they will continue to do something if the Federal Government does not come in and take away both the incentive and the opportunity by putting in what is termed affectionately ''a floor,'' a minimum.

The problem is these minimums very often become the ceiling or they become, if you will, the top of whatever is being done because the States will not have the same opportunity, nor will they have the same willingness with the Federal deregulation, of the federalization of the regulation of State insurance as it applies to these health plans.

Generally preemption occurs when the States have not acted. I cannot imagine we are now preempting what the States have done on the basis of they have done such a good job that we were able to pick and choose from the best of those protections to create this bill and now we say to them: It's a job well done; thank you very much, and, by the way, we will impose these on you and we will make sure your laws will have to be either substantially equivalent or consistent with, according to Frist-Breaux, or, with the compromise, substantially compliant.

I can understand our desire to take over the role of the States in this area if the States have not done anything, but I cannot understand the desire to do it when the States have done such a good job that we have picked and chosen from the best of those efforts to comprise our bill.

It does not make sense to preempt under these circumstances. That is why many of us would like to see the States have the opportunity to opt out so we will have continuing experimentation under the Jefferson principle that the States are the laboratories of democracy. I am not against all preemptions, but I do have a question about this preemption, whether it makes sense under the circumstances with the progress that the States have made.

The charts will show the States have been active. They have worked very hard and diligently and are continuing to do so. Delaware just last week enacted additional patient protection laws. What we need to do is make sure we continue to permit the States to experiment.

I am also worried that with the application of these standards to the States, we will not have further experimentation, we will not have further development of patient protections. I hate to think we are at a point where the status quo will be sufficient for today as well as for tomorrow. I worry this effort in having a floor will result in it becoming a ceiling.

If you look at the charts, you will see to one degree or another, whether it is emergency room or whether it is the external appeals or the internal appeals, that nearly every State is doing it. Many States have decided not to do everything under every set of circumstances. I do not think they ought to be penalized where they have made a conscious decision that that is not going to work within their State. We ought not to have, in my judgment, a one-size-fits-all approach. We have not found, if you will, the Holy Grail as it relates to what patient protection truly is. If we allow the States to continue to experiment, we will find that they will be innovative and they will come up with new methods of providing even better patient protections. After all, this is coming from the grassroots; this is coming from the bottom up.

I think we are making a mistake trying to drive it from the top down which will stifle and create the opportunity for stagnation rather than experimentation. I hope that will not be the case, but I do not see it really any other way.

The National Association of Insurance Commissioners, the president of the National Association of Insurance Commissioners, the National Council of State Legislators all agree with this approach.

The ACTING PRESIDENT pro tempore. The Senator's time has expired.

Who yields time?

Mr. BREAUX. I yield 5 minutes to Senator JEFFORDS.

The ACTING PRESIDENT pro tempore. The Senator from Vermont is recognized for 5 minutes.

Mr. JEFFORDS. Mr. President, I commend the Senator from Maine for keeping this issue alive. It is critically important that we defer as much as we can to the States because they are already set up for it. Why not let them do it?

On the other hand, this is a Federal Patients' Bill of Rights. That means equal rights to everyone in this country, so there is a requirement for uniformity as well as to make sure we get a firm and even enforcement of this bill.

A lot has been said about HIPAA and using HIPAA as an example of bad policy, and it was bad policy, but it was totally different. HIPAA dealt with portability of insurance in the case of people being laid off work.

They said, if you do not do it, HCFA will come in and do it, and five States said let HCFA do it, and it made a mess of it. This is different. We are talking about the enforcement of rights, an even enforcement across the country. Yet we do recognize it is important for the States to do it themselves. Many, if not most of them, are already doing a legislative enforcement to require the appropriate and fair enforcement of the rights of individuals on health care.

This is an important difference. HIPAA was a mess, but this has nothing to do with that. This is quite different from HIPAA.

We all support the Patients' Bill of Rights. The question is who ought to

enforce it. We say, yes, let the States that want to do it do it. On the other hand, we need to make sure it is done fairly and uniformly across this country. We do give the authority to the Secretary to review it, and we also say he should lean over backwards to make sure the States do it if at all possible. It is not a HIPAA-type situation; we ought to differentiate that.

It is important that we also recognize that the compromise requires States to have protections that are ''substantially compliant with'' Federal protection and defines this standard as having the ''same or similar provisions and the same or similar effect.''

The Secretary must approve the State's certification of compliance in a manner that is in deference to existing State laws. If he does not act on the State application within 90 days, it is automatically approved. States that have their certification disapproved may challenge that disapproval in court.

The amendment developed by Senator BREAUX and myself requires States with additional flexibility to implement strong patient protections while guaranteeing a basic level of protection for all Americans in all health plans. Requiring the States to be in substantial compliance with the Federal law—not exact compliance but substantial compliance—provides States with the flexibility they need to implement strong patient protections while ensuring that all patients receive the Federal floor of protections. Under this amendment, States can keep their own laws as long as their basic intent is similar to the Federal standard and will have a similar effect.

The Secretary is required to be deferential to the States—give them every break you can but make sure that the bill of rights will be enforced. Give them every possible opportunity to do it themselves rather than having to go to court. However, this requirement does not infringe upon the Secretary's authority to determine whether current State laws will provide the basic level of protection promised to all Americans in the health plans under the Patients' Bill of Rights.

So HIPAA is just a totally different situation. It is a mess; we agree with that; but it is totally different. Do not get confused on the HIPAA example.

Mr. President, I yield the floor.

The ACTING PRESIDENT pro tempore. Who yields time?

The Senator from Maine.

Ms. COLLINS. How much time is remaining on my side?

The ACTING PRESIDENT pro tempore. Three minutes forty-seven seconds.

Ms. COLLINS. Mr. President, I yield 2½ minutes to the Senator from Ohio, Mr. VOINOVICH.

The ACTING PRESIDENT pro tempore. The Senator from Ohio is recognized.

Mr. VOINOVICH. Mr. President, I thank my friends from Maine and Nebraska for offering this important amendment. I believe the Collins-Nelson amendment will allow the Senate to move forward and pass a strong Federal patient protection bill without suffocating the patient protections States have adopted over the last several years.

I wholeheartedly agree that the Senate should take action to protect those Americans not covered under state plans. While the states were in front protecting the majority of those insured individuals through state regulation, the federal government has dragged its feet.

However, a federal patient's bill of rights should not preempt the patient protections that have already been passed by the states. There are more than 117 million Americans who are covered under fully insured plans, governmental plans and individuals policies, which are all regulated under state law.

My colleagues supporting the McCain-Kennedy legislation believe that the federal mandates in the bill should apply not only to ERISA plans, but also to those 117 million Americans in state regulated health plans. Apparently, they do not think that the states, which have already acted and are already protecting millions of Americans, are competent enough to do the job. Instead, they think that the federal government will do a much better job.

My colleagues on the other side of this debate want the public to believe that all Americans need to be covered under a federal patient protections bill or else the quality of their health care will be jeopardized. The fact of the matter is that the majority of Americans are already covered under very good, very comprehensive state health care laws.

As a former Governor of Ohio, I was on the front lines in the fight to give working men and women in Ohio real health care choices. As governor, I signed into law five legislative measures and pushed through several administrative improvements to protect families who relied on state-regulated plans for their health care coverage.

The majority of states, including Ohio, have moved aggressively—certainly more quickly than the federal government—to reduce health care inflation, expand access for the working poor, enhance consumer protections and bring greater accountability to the system.

If the states had waited for the federal government to step up to the plate to provide patient protections, 117 million Americans would not have the patient protections they currently enjoy.

The simple truth is that the states have been out in front of the federal government in providing sound protections for its citizens. The following facts prove this point:

42 states have already enacted a comprehensive Patient's Bill of Rights;

50 states have mandated strong patient information provisions;

50 states already have an internal appeals process and 41 states have included an external appeals process;

48 states already enforce consumer protections regarding gag clauses on doctor-patient communications;

47 states already have regulations regarding prompt payment; and

44 states already enforce consumer protections for access to emergency care services.

The states are already getting the job done for the majority of insured Americans. But if we do not pass this amendment, we will be turning over to the Health Care Financing Administration (HCFA) the enforcement of state sponsored protection plans that are not substantially equivalent with the federal bill.

The fact is, HCFA already has its hands full. Administering and regulating Medicare and Medicaid has already overburdened this federal agency. Think about it. HCFA already has under its purview over 70 million Americans through these federal programs. Now, my colleagues want to place the health care of an additional 170 million Americans on HCFA's shoulders.

The simple fact is that HCFA cannot handle the burden.

Those individuals on the front lines of protecting the 117 million Americans with state regulated insurance know what will happen if the federal government is given the responsibility to oversee these state regulated health insurance plans.

In fact, the National Conference of State Legislatures has described the McCain-Kennedy bill as, ''. . . federal legislation that will largely preempt important state laws and replace them with federal laws that . . . the federal government is ill-prepared to monitor and enforce.''

Additionally, the National Association of Insurance Commissioners has made clear its concerns about the McCain-Kennedy bill: if the federal government unilaterally imposes a one-size-fits-all standard on the states, it ''could be devastating to state insurance markets.''

The amendment that Senators COLLINS and NELSON have offered will give true deference to state laws and the traditional authority that states have had to regulate insurance.

By ''grandfathering'' all state patient protection laws, Senators COLLINS and NELSON recognize that the vast majority of states have enacted comprehensive patient protections laws, as Ohio has done.

The amendment also encourages states, through Patient Quality Enhancement Grants, to review their current patient protection and, if the state legislature and governor so desire, take action to mirror federal patient protections.

I want to relay to my colleagues that I truly believe that this will be the most important federalism vote that the Senate takes this year.

In conclusion, it has been the traditional role of States to regulate the needs of our States. However, both the McCain-Kennedy bill as written and the Breaux amendment seek to preempt what the States have accomplished in protecting patients. The underlying bill as written would step over the 10th amendment which says: the powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.

The bottom line is that the States have been involved in protecting patients a lot longer than the Federal Government, and they are doing a good job with the protections they have put in place. They debated them in their State legislatures. Their insurance departments are doing a good job of enforcing those laws. The Breaux amendment and the underlying bill gets the States out of their role. We will have a dual system of enforcement—State insurance commissioners and HCFA. And I can tell you, anyone who knows anything about HCFA in terms of the responsibilities they have, knows they have a hard-enough time doing their job now. We should not get them involved in a system that is already working on the State level.

I beg my colleagues not to go along with federalizing this issue. Let's take care of the Federal people who have been exempted over the years because we haven't done the job we are supposed to do, and let the States continue to do the job they have been doing.

I thank the Chair.

The ACTING PRESIDENT pro tempore. Who yields time?

Mr. BREAUX. I yield 2½ minutes to my good friend, the Senator from Connecticut.

The ACTING PRESIDENT pro tempore. The Senator from Connecticut is recognized.

Mr. DODD. Mr. President, I thank my colleague from Louisiana. I commend him and the Senator from Vermont for their compromise proposal we will be voting on shortly. I reluctantly oppose my friend from Maine, my fellow New Englander. I have joined with her on so many issues and have such great respect for her.

There is a title to this bill. It is not titled casually; it is called the Patients' Bill of Rights. We talk about a bill of rights. Obviously we are all most familiar with our Constitution and the Bill of Rights we embrace and cherish so richly as American citizens. But if we are going to have a bill of rights when it comes to basic fundamental health care, as has been pointed out by the Senator from Louisiana and the Senator from Massachusetts and others, then there ought to be a floor that applies across the country to all 50 States. That is what we are really advocating.

If the Collins amendment is adopted, then what you are developing is a trapdoor in that basic floor that exists. Let me make the case just by pointing to one particular provision of this bill. That is the access to emergency room care, Mr. President.

I have this chart to make the point. In the States that are in red in this chart, they have laws that are weaker than the underlying bill when it comes to access to emergency rooms. We are not talking about some grandiose new plan. We are talking about a fundamental right that you can have access to the closest emergency room. In 27 States, they have a much weaker provision than is in this law. We are saying when it comes to a Patients' Bill of Rights, access to clinical trials, specialists, emergency rooms, this is the floor across the country. If you want to pass laws at the State level that are substantially in compliance with that, we welcome that. If you want to do something more than we are doing here, we welcome that. But if you are going to say that we are going to allow weaker laws to exist in the access to a gynecologist, to a pediatrician, to a clinical trial, to a specialist, or to an emergency room, then we don't think that is right.

If you are for the Collins amendment, in many ways you are going against this bill. I understand that. I appreciate the fact that people do not want to pass a Patients' Bill of Rights and just leave it up to each State to decide. But if you believe, as a majority of us do, and an overwhelming majority of the American public, that there ought to be a Patients' Bill of Rights, a basic floor that provides these basic standards, then you must vote to adopt the Breaux-Jeffords compromise amendment and retain the integrity of this bill.

The ACTING PRESIDENT pro tempore. The Senator's time has expired. Who yields time?

Mr. KENNEDY. I imagine the Senator would like to close the debate, would she not?

I believe I have 2½ minutes.

Mr. President, the issue is very simple and very basic and very fundamental. It is whether all Americans are going to be covered as included in this legislation. We do not believe it should depend upon where you live. We believe it should depend necessarily on where you work. If a child needs a specialist to treat cancer, he or she ought to be entitled to see the specialist and receive the treatment. If a woman needs to be enrolled in a clinical trial that could be lifesaving, she ought to be entitled to participate. If a breadwinner who is crippled with arthritis needs a specialty kind of drug from a formulary, he or she ought to be able to obtain it.

Now, our bill guarantees these kinds of protections, but with the Collins amendment it is a roll of the dice. President Bush believes that all Americans should be covered. Every Republican bill that was introduced and considered in the House of Representatives said all Americans are covered. She covers about 40 percent of them; 60 percent of Americans are left out. We believe if you are interested in assuring that all Americans be covered, you ought to support the Breaux-Jeffords amendment. That will be doing the right thing.

The ACTING PRESIDENT pro tempore. The Senator from Maine is recognized.

Ms. COLLINS. Mr. President, one of the myths in this debate is that unless the Federal Government preempts State insurance laws, somehow millions of Americans will be unprotected in their disputes with HMOs. That is simply untrue. Ironically, my friend from Connecticut makes the point on emergency room care. Forty-four States have enacted legislation guaranteeing access to the nearest emergency room. But they have crafted their laws in different ways depending on the needs of those States. Why should the Federal Government second-guess those laws, substitute its judgment for the judgment of State legislators and Governors' offices all over this country? It does not make sense. The proposal of the Senator from Louisiana would be both burdensome to States and ineffective for consumers.

Does anyone really believe that a consumer with a problem with his or her insurance policy is better off calling the HCFA office in Baltimore than dealing with their own State bureau of insurance?

The States have more than 50 years of experience in regulating insurance. They have acted without any prod or mandate from Washington to enact good, strong patient protection laws. Let's honor their work. Let's build upon the good works of the States rather than preempting, second-guessing, and superseding their laws.

The ACTING PRESIDENT pro tempore. Who yields time?

Ms. COLLINS. Is there any time remaining?

The ACTING PRESIDENT pro tempore. The Senator from Maine has 24 seconds.

Ms. COLLINS. I yield back the remainder of my time if the other side is ready to yield back.

I ask for the yeas and nays on the amendment.

The ACTING PRESIDENT pro tempore. All time is yielded back. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. REID. Mr. President, I move to table the Collins amendment and ask for the yeas and nays.

The ACTING PRESIDENT pro tempore. Is there a sufficient second? There is a sufficient second.

The question is on agreeing to the motion.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. REID. I announce that the Senator from Delaware (Mr. BIDEN) is necessarily absent.

Mr. NICKLES. I announce that the Senator from New Mexico (Mr. DOMENICI) and the Senator from Alabama (Mr. SHELBY) are necessarily absent.

The PRESIDING OFFICER (Mr. REED). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 53, nays 44, as follows:

[Rollcall Vote No. 202 Leg.]

YEAS—53

| | | |
|---|---|---|
| Akaka | Dodd | Levin |
| Baucus | Dorgan | Lieberman |
| Bayh | Durbin | Lincoln |
| Bingaman | Edwards | McCain |
| Boxer | Feingold | Mikulski |
| Breaux | Feinstein | Miller |
| Byrd | Fitzgerald | Murray |
| Cantwell | Graham | Nelson (FL) |
| Carnahan | Harkin | Reed |
| Carper | Hollings | Reid |
| Chafee | Inouye | Rockefeller |
| Cleland | Jeffords | Sarbanes |
| Clinton | Johnson | Schumer |
| Conrad | Kennedy | Stabenow |
| Corzine | Kerry | Torricelli |
| Daschle | Kohl | Wellstone |
| Dayton | Landrieu | Wyden |
| DeWine | Leahy | |

NAYS—44

| | | |
|---|---|---|
| Allard | Gramm | Nickles |
| Allen | Grassley | Roberts |
| Bennett | Gregg | Santorum |
| Bond | Hagel | Sessions |
| Brownback | Hatch | Smith (NH) |
| Bunning | Helms | Smith (OR) |
| Burns | Hutchinson | Snowe |
| Campbell | Hutchison | Specter |
| Cochran | Inhofe | Stevens |
| Collins | Kyl | Thomas |
| Craig | Lott | Thompson |
| Crapo | Lugar | Thurmond |
| Ensign | McConnell | Voinovich |
| Enzi | Murkowski | Warner |
| Frist | Nelson (NE) | |

NOT VOTING—3

| | | |
|---|---|---|
| Biden | Domenici | Shelby |

The motion was agreed to.

Mr. KENNEDY. I move to reconsider the vote.

Mr. INOUYE. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 830

The PRESIDING OFFICER. Under the previous order, there will now be 2 minutes for debate equally divided prior to a vote on or in relation to the Breaux amendment No. 830.

Who yields time?

Mr. BREAUX. Mr. President, I do not mind using the time allocated for remarks, but in light of the previous vote, after the remarks could we just vitiate the rollcall vote and have a voice vote on this amendment? I ask unanimous consent that that be in order.

The PRESIDING OFFICER. The yeas and nays have not been ordered on the Breaux amendment No. 830.

Mr. BREAUX. That would be my suggestion. We have the time allocated for comments on it, and then have a voice vote on it afterward.

Mr. KENNEDY. Mr. President, I think we will have the Senator from Minnesota speaking for 2 minutes, and then I think we will voice vote the Breaux-Jeffords amendment.

The PRESIDING OFFICER. Who yields time?

Mr. BREAUX. I yield 2 minutes to the Senator from Minnesota.

Mr. WELLSTONE. I thank my colleague for his graciousness.

Mr. President, I understand the need to compromise, and I think we are moving forward in a very positive way. I do want to point out for the record that what we are now saying is that a State need only be ''substantially compliant'' with Federal protections as opposed to ''substantially equivalent to.'' My big worry is that if you look at this amendment, we are also saying we need to give deference to the State's interpretation of its own law and its compliance with Federal protections.

I say two things to colleagues. No. 1, I think, in the best of all worlds, consumers would also have a right to appeal if they believe the State is in error.

To be fair, we want to give deference to what States are doing, as long as we have strong consumer protections for everyone regardless of where they live. I also believe if we are going to do that, we have to make sure not only that the States are given their proper due but so are consumers.

This amendment weakens the bill somewhat. I have said that to Senator BREAUX. Frankly, more than anything, it would be helpful to have an ombudsman office or something such as that in every State, where people would know where to make a phone call, know what their rights are. There are ways we can strengthen this.

I do not believe this amendment takes us in a strong consumer direction. It is a good compromise in terms of where we are. I wanted to speak out and express my concerns.

The PRESIDING OFFICER. All time on the amendment has expired.

The question is on agreeing to amendment No. 830.

Mr. KYL. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second. The clerk will call the roll.

The assistant legislative clerk called the roll.

The result was announced—yeas 64, nays 36, as follows:

[Rollcall Vote No. 203 Leg.]

YEAS—64

| | | |
|---|---|---|
| Akaka | Dodd | Levin |
| Baucus | Dorgan | Lieberman |
| Bayh | Edwards | Lincoln |
| Biden | Ensign | Lugar |
| Bingaman | Feingold | McCain |
| Boxer | Feinstein | Mikulski |
| Breaux | Fitzgerald | Miller |
| Byrd | Frist | Murray |
| Cantwell | Graham | Nelson (FL) |
| Carnahan | Harkin | Nelson (NE) |
| Carper | Hollings | Reed |
| Chafee | Hutchison | Reid |
| Cleland | Inouye | Rockefeller |
| Clinton | Jeffords | Santorum |
| Cochran | Johnson | Sarbanes |
| Conrad | Kennedy | Schumer |
| Corzine | Kerry | Smith (OR) |
| Daschle | Kohl | Snowe |
| Dayton | Landrieu | Specter |
| DeWine | Leahy | Stevens |
| Stabenow | Torricelli | Warner |
| | | Wyden |

NAYS—36

| | | |
|---|---|---|
| Allard | Durbin | McConnell |
| Allen | Enzi | Murkowski |
| Bennett | Gramm | Nickles |
| Bond | Grassley | Roberts |
| Brownback | Gregg | Sessions |
| Bunning | Hagel | Shelby |
| Burns | Hatch | Smith (NH) |
| Campbell | Helms | Thomas |
| Collins | Hutchinson | Thompson |
| Craig | Inhofe | Thurmond |
| Crapo | Kyl | Voinovich |
| Domenici | Lott | Wellstone |

The amendment (No. 830) was agreed to.

Mr. REID. I move to reconsider the vote.

Mr. DORGAN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. Under the previous order, the Senator from New Hampshire, or his designee, is recognized to offer an amendment relative to liability on which there will be 1 hour of debate.

Mr. REID. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BOND. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 831

Mr. BOND. Mr. President, I send an amendment to the desk on behalf of myself, Mr. ROBERTS, and Mr. HELMS, and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Missouri [Mr. BOND], for himself, Mr. ROBERTS, and Mr. HELMS, proposes an amendment numbered 831.

Mr. BOND. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To ensure that patients receive a minimum share of any settlement or award in a cause of action under this Act)

On page 154, between lines 2 and 3, insert the following:

''(11) MINIMUM SHARE OF SETTLEMENT OF AWARD.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), a participant or beneficiary (or the estate of such participant or beneficiary) shall receive not less than 85 percent of any award made as a result of a cause of action brought by the participant or beneficiary (or estate) under this subsection, after subtracting the amount of any attorneys' fees from the total amount of such award.

''(B) EXCEPTION.—This paragraph shall not apply where the amount awarded as a result of a cause of action brought by a participant or beneficiary (or estate) under this subsection is less than $100,000.

''(C) DEFINITIONS.—In this paragraph:

''(i) ATTORNEYS' FEES.—The term 'attorneys' fees' means any compensation for the

direct or indirect representation or other legal work performed in connection with a cause of action brought under this subsection. Such term shall not include reimbursements for any expenses incurred in connection with such representation or work.

''(ii) AWARD.—The term 'award' means the sum of—

''(I) any monetary consideration provided to a participant or beneficiary (or the estate of such participant or beneficiary) by a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with a group health plan, or an agent of the plan, issuer, or plan sponsor in connection with a cause of action brought under this subsection, including any monetary consideration provided for in any—

''(aa) final court decision;

''(bb) court order;

''(cc) settlement agreement;

''(dd) arbitration procedure; or

''(ee) alternative dispute resolution procedure (including mediation); plus

''(II) any attorney's fees awarded under subsection (g)(1) with respect to the participant or beneficiary (or estate); less

''(III) any reimbursement for any expenses incurred in connection with direct or indirect representation or other legal work performed in connection with a cause of action under this subsection.

On page 169, between lines 12 and 13, insert the following:

''(11) MINIMUM SHARE OF SETTLEMENT OF AWARD.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), a participant or beneficiary (or the estate of such participant or beneficiary) shall receive not less than 85 percent of any award made as a result of a cause of action brought by the participant or beneficiary (or estate) under this subsection, after subtracting the amount of any attorneys' fees from the total amount of such award.

''(B) EXCEPTION.—This paragraph shall not apply where the amount awarded as a result of a cause of action brought by a participant or beneficiary (or estate) under this subsection is less than $100,000.

''(C) DEFINITIONS.—In this paragraph:

''(i) ATTORNEYS' FEES.—The term 'attorneys' fees' means any compensation for the direct or indirect representation or other legal work performed in connection with a cause of action brought under this subsection. Such term shall not include reimbursements for any expenses incurred in connection with such representation or work.

''(ii) AWARD.—The term 'award' means the sum of—

''(I) any monetary consideration provided to a participant or beneficiary (or the estate of such participant or beneficiary) by a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with a group health plan, or an agent of the plan, issuer, or plan sponsor in connection with a cause of action brought under this subsection, including any monetary consideration provided for in any—

''(aa) final court decision;

''(bb) court order;

''(cc) settlement agreement;

''(dd) arbitration procedure; or

''(ee) alternative dispute resolution procedure (including mediation); less

''(II) any reimbursement for any expenses incurred in connection with direct or indirect representation or other legal work performed in connection with a cause of action under this subsection.''

Mr. BOND. Mr. President, several days ago in debate in this Chamber, I talked about how the employees of small businesses might lose their health care coverage if the provisions of McCain-Kennedy went into effect unamended. The junior Senator from North Carolina indicated that I was interested only in protecting the businesses.

Unfortunately, he misconstrued my arguments because we are concerned about patients. We hope the employees of small businesses will continue to get the benefit of health insurance coverage by their employers.

I spoke about employees, however, because if this bill is not significantly amended, there are not going to be patients covered by this bill; they are going to be thrown out of health care coverage. We are concerned about patients.

It is not only small businesses that should be worried about this bill, but employees of small businesses should also be worried about this bill.

This amendment I offer today provides additional protection to patients. It provides protection to patients from trial lawyers, so we will find out whether my colleagues are more interested in taking care of patients or ensuring that the rights to sue by trial lawyers are unabated.

There are a lot of words in the McCain-Kennedy bill, but there are also some heavy-duty new lawsuits that are authorized.

The Federal claim of action really begins on page 140. It starts off:

IN GENERAL.—In any case in which

(A) a person is a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with the plan, or agent of the plan, issuer, or plan sponsor—. . . .

Cause of action starts off, No. 1, regarding whether an item of service is covered under the terms; No. 2, regarding whether an individual is a participant or beneficiary; No. 3, application of cost-sharing requirements.

Then there is the real hooker; there is the bombshell that opens this baby up to anybody who really likes to file lawsuits. It says:

. . . otherwise fails to exercise ordinary care in the performance of a duty under the terms and conditions of the plan with respect to a participant or beneficiary.

There are tons of laws that are covered here—HIPAA and COBRA. This is a wonderful opportunity for our brothers and sisters of the trial bar to file lawsuits. That is the Federal side.

Then on page 157, it talks about State causes of action. It starts off, as this bill does—my good friend, the Senator from Texas points out all the bad stuff they do to providers of health insurance begins with ''does not apply,'' ''except.''

Preemption does not apply. ''nonpreemption of certain causes.'' It begins on page 157:

Except as provided in this subsection, nothing in this title . . . shall be construed to supersede or otherwise alter. . . .

It goes on page after page. There are exceptions for wrongful death, exceptions for willful disregard of safety of others; their definition of certain causes of action permitted. Somewhere around page 172 it gets to the point: Certain actions are allowable.

Basically, these pages of this bill provide tremendous opportunities to bring lawsuits. We should be talking about protecting patients, not about protecting trial lawyers.

I believe it is appropriate now that we consider some protection against the HMOs and the insurance companies, important as that is, and instead make sure that we protect patients against trial lawyers.

There are a lot of stories going on about trial lawyers: they are taking advantage of their clients; some attorneys ask for 40 to 50 percent of any settlement; refuse to negotiate with clients; contingency fees of 33 or 40 percent are common. Some trial lawyers flat out refuse to take a case based on an hourly fee, and they demand they be able to take a huge percentage of the award. They also take their out-of-pocket expenses off the top before the contingency fee is applied, and that means in some circumstances the injured party, the plaintiff, gets less than the plaintiff's attorney.

I think that is outrageous. As a former attorney, as a recovering attorney, I realize lawyers perform useful services when someone is harmed. They should be justly compensated.

However, this amendment says enough is enough. The amendment is very simple. Any patient who gets a monetary award through all the new lawsuits permitted in the McCain-Kennedy bill must get at least 85 percent of the award. If you are hurt, doesn't it make sense to receive 85 percent of it? I can't see that being objectionable. The amendment effectively prohibits obscene contingency fees where large judgments are won and the plaintiff's attorney takes 30 or 40 percent after deducting all the expenses.

Some may say lawyers will not take the cases. When we talk about setting a patient minimum, we need to be cautious. Just as it doesn't help to have a right to sue your HMO when your employer drops health care coverage, as would happen under this bill if it is not amended, it doesn't help to have a strong patient minimum requirement if it means no attorney will take your case. This amendment includes two strong protections to make sure access to attorneys is not threatened.

First, before the patient minimum is applied, the amendment allows the attorney to be reimbursed for expenses incurred during the case. Only after expenses are deducted from the award will a patient minimum apply. In practice, this means an attorney can never lose money on a lawsuit that results in an award.

Second, we exempt certain lower level awards from the patient minimum requirement. This ensures that the simpler cases that don't promise large awards can still be pursued and

are not limited by the requirement that the patient gets 85 percent. We have set $100,000, which is above the median judgment normally entered in malpractice cases, as the limit.

I am not sure any State has taken the exact approach this amendment establishes with a patient minimum, but 14 States have established caps on attorney fees. The strictest cap is in New York where lawyers are limited to 10 percent of awards over $1.25 million. That is the equivalent of a 90-percent patient minimum. California has the most well-known cap on attorney fees. In California, lawyers are limited to 15 percent of any award in excess of $600,000. When you add Florida and Indiana, which also have a 15-percent cap for the highest level awards, 4 of the 14 States that established caps on awards of attorney fees essentially require that plaintiffs get at least 85 percent of an award.

Have these caps served as a barrier for plaintiffs? Have they denied access to the courts? From the data we have, we conclude they definitely have not. The State with the toughest cap, New York, produces almost twice as many malpractice awards per capita as the national average. The national malpractice per year per million residents, the U.S. average, is 49.2; California is 47.2; New York is 99.5, more than twice the normal national level. From the other States with tough caps, Florida has an average number of malpractice awards per capita and California's rate is about the average. Indiana, with a 15-percent cap, falls below the national average.

It is hard to argue that the caps threaten access to the courts through attorneys. The California law has existed for at least a decade. By not changing the law, the State legislature seems to have come to the same conclusion.

Why do we take 85 percent? When you take out expenses and exempt lower level awards, patients should get the overwhelming amount of an award. For a patient who has been harmed, it is perfectly reasonable to ask that that patient get 85 percent. For States with similar requirements, there does not seem to be a barrier to finding attorneys and bringing a lawsuit if you believe you have been harmed. To my knowledge, none of these States has repealed their caps, demonstrating that at least the State legislatures think they are working. By choosing 85 percent as the absolute minimum amount to which a patient is entitled, this amendment simply reconciles Federal law with laws that seem to be working in four of the largest States in this country.

We know of the horror stories. We have heard too many horror stories. I point out an August 16, 2000, article in the Los Angeles times about Rodney King, who was brutally beaten by Los Angeles police. He is taking a beating from his lawyers, he says. They made more money on his case than he has. By his reckoning, they cheated him out of more than $1 million. In a nutshell, the man whose 1991 videotaped beating made him an international symbol of police abuse said he thought he had a deal with his lawyer to pay them only 25 percent of the award but they wound up showing King's lawyers received $2.3 million while he got only $1.9 million.

Another lawyer in California won a class action suit for police brutality and civil rights and took a $44,000 verdict in the case, a $19,800 contingency fee, and collected $378,000 in fees awarded by the trial court; the client received $810.

I have other examples. But one of my favorites is the Lawyers Weekly report that a growing number of lawyers are putting arbitration clauses in the fine print, shielding them from being sued by another trial lawyer if the clients say they botched a case. The lawyers themselves who are making the money off the large judgments prefer their disputes go to private arbitration because arbitration is faster, cheaper, decisions are made by other lawyers rather than juries, and there is no public record. So they have recognized that there are certain instances in which it does not make sense to allow unfettered access to the courts for people with a claim.

If a patient is harmed and wins an award through a lawsuit, it is perfectly reasonable to expect the patient will receive at least 85 percent of the money. Almost 180 pages of the bill protect patients from HMOs and insurance companies. I simply propose we add a few pages to the bill to protect patients from trial lawyers.

I see the Senator from North Dakota is on the floor. I ask after the other side finishes speaking that my colleague from Iowa be recognized for 10 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from North Dakota is recognized.

Mr. DORGAN. Mr. President, this amendment is one more in a series of amendments designed to try to derail the Patients' Bill of Rights, or the Patient Protection Act.

There is no evidence of unfairness in the attorney fee portion of the bill that we brought to the floor of the Senate. No one has alleged that; no one has discussed that with us. This is the first moment in which there is an amendment offered and we have been working on this legislation for five years. It is interesting that the amendments are always designed to try to take the ground out from under patients, to diminish the opportunity for the patients to address the enormous problems they face in confronting a managed care organization that does not want to give the care promised the patients.

This amendment ultimately prevents injured patients from finding the adequate legal protection they need in order to confront a managed care organization. Congress has passed over 300 laws allowing attorney fees, and the laws are described for every Senator to see in a Congressional Research Service report No. 94–870–8. I commend anyone to that CRS report which describes these laws.

I have not found any Federal law on attorney's fees that is as restrictive as is proposed in this amendment. I repeat, there isn't any Federal law on attorney's fees that is as restrictive as that proposed this morning on the Patient Protection Act.

Why, when we have this issue of managed care organizations not providing the care required for patients and we have the opportunity in this legislation to hold the managed care organization accountable, why is it that those who don't like this Patient Protection Act try to carve the ground out from under patients once again with a restrictive proposal that almost certainly would diminish the opportunity of a patient to acquire access to an attorney to make that HMO accountable?

I find it also interesting that the concern behind this Bond amendment is apparently excessive attorney fees. There are striking excesses with respect to managed care organizations. Let me mention just a couple.

What about excessive salaries, excessive stock options? I don't hear anyone coming to the floor of the Senate complaining about $50 million in compensation that the CEO of a managed care organization receives. I don't hear anybody saying that is an excessive salary for an individual to receive. How is it these CEO's get to be rewarded in amounts a large as $50 million? By pinching on access to care that ought to be delivered to patients.

The opponents of our patients protection bill are not here on the floor saying that $50 million paid to the president of a managed care organization is excessive. We just hear them come out here to say we are worried about an excessive fee received by an attorney who is representing a patient trying to hold an HMO accountable.

Mr. REID. Will the Senator yield for a question?

Mr. DORGAN. I will be happy to yield, of course.

Mr. REID. Is the Senator aware that William McGuire of UnitedHealth Group earned $54.1 million last year?

Mr. DORGAN. I am aware of that.

Mr. REID. Is the Senator aware that there were unexercised stock options worth an additional $68 million by various people with that company, but McGuire held the most stock options, worth $358 million? Is the Senator aware of that?

Mr. DORGAN. I am aware of published reports that say that, yes.

Mr. REID. Did I hear the Senator say he has not heard any debate on the Senate floor this past 10 days about this excessive, exorbitant amount of dollars to the people who run these companies and not helping the patients? I have not heard that; has the Senator?

Mr. DORGAN. The Senator from Nevada is correct. We have not heard one

word from opponents to our patients protection bill about the salaries, stock options, and the compensation paid to those who run the managed care organizations.

Let me go back to the intention of our Patients' Bill of Rights, and then bring it to this amendment. The reason we are here in the first instance is because too many people in managed care organizations are not getting the care they need. Too many people do not get the care they need or expect from their health care plan, and they are not able to hold the health care plan accountable for it.

This legislation says there ought to be protections in place for patients. Patients ought to be able to know all their options for medical treatment, not just the cheapest option. That is a patient's right. That is what we say in this legislation.

Some people do not want that. The managed care group does not want that. The insurance companies do not want that. We say a patient ought to have a right to emergency room treatment when they have an emergency. That is a right that is in this bill that we are trying to get passed. I understand why the managed care groups don't want that. I understand why there are some who oppose it here in the Senate because they stand with the insurance companies and the managed care groups. We stand with the patients saying there ought to be basic protections in place.

This amendment is one more attempt, by our opponents, in a series of attempts just to undermine this bill, to say no, we don't stand with patients, we don't stand with patients in order to allow them to exercise the rights that are in this bill. What our opponents would like to do is chip away and carve away at the foundation of this bill so at the end of the day the patients do not have these protections and the patients do not have these rights.

This amendment, if it were genuine, if it were really concerned about fees, would not just address attorney's fees. They would address the compensation paid to those who run these organizations, who make $50 million, $10 million, or $250 million in stock options. Is that excessive? We don't hear anyone on the floor of the Senate talking about that.

Why? Because this is not about fees. It is about with whom do you stand. It is about people who really do not want this legislation to pass. They have been dragging their feet now, day after day after day, bringing out amendments to try to defeat the Patients Protection Act. In every case, in every circumstance, they have failed. This amendment is the latest attempt to do that. The amendment limits attorney's fees in circumstances where patients would try to hold a managed care organization accountable. It limits attorney's fees, as I understand it, to an amount below all other attorney's fees that are now written in Federal law. We have it in a number of places in Federal law. I have referenced the CRS report. All Senators can look at it.

This amendment proposes we limit attorney fees below all those other areas mandated by federal law. Why? Because here we are talking about patients. We are trying to advocate on behalf of patients. Why would anyone want to take away the patients' rights when they are confronting big organizations?

One of the interesting things is I hear all this talk about a patient who would hire an attorney to make a managed care organization accountable. I hear no discussion about the legion of attorneys who are hired by managed care organizations to deal with patients—none. Do you think the big insurance companies and big managed care organizations do not have a battalion of lawyers they pay? Of course they do. Maybe you want to limit their opportunity to use lawyers? I don't think so. I don't propose that.

Then why would you want to limit the opportunity of patients to use attorneys to make an HMO accountable? This just makes no sense on its face. It is one more step, one more attempt to try to defeat this bill. We have had it day after day after day, amendment after amendment. I hope my colleagues will understand the last thing we ought to do is weaken the ability of the American people, who as medical patients expected certain care but did not get it, to be able to hire an attorney and make that managed care organization accountable.

I would say one more thing. I would like those who offered this amendment, who are indeed concerned about ''fees,'' to be concerned about all fees. If they are concerned about lawyer's fees, good for you. Then be also concerned about $50 million, and $250 million in compensation paid to a CEO who runs a managed care organization. Be concerned about those fees as well. You want to be consistent, bring both amendments to the floor and let's debate both amendments.

I reserve the remainder of my time and yield the floor.

The PRESIDING OFFICER (Mrs. CARNAHAN). Under the previous order, the Senator from Iowa is recognized for 10 minutes.

Mr. REID. The two leaders are on the floor. I think they are about ready to propose a unanimous consent request. If they are not now, would the Senator mind yielding when they are ready?

Mr. GRASSLEY. I would rather wait. Hopefully, they will do it right now.

Mr. REID. Madam President, I suggest the absence of a quorum and I ask unanimous consent to have the time run equally on this amendment.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Iowa.

Mr. GRASSLEY. Madam President, I support the Bond amendment and want to speak specifically to that point. It also deals with the point I have made in other speeches—that this is a very good bill. But during the process of considering giving patients a bill of rights against insurance companies, I think we always have to keep our eye focused upon the fact that we want to give treatment for patients and not tribute for lawyers.

This amendment takes a very good approach in fixing the Kennedy-McCain bill's provisions dealing with the liability parts of the bill, which, in my view, amount to nothing less than a trial lawyer's pot of gold.

I have always believed that medical malpractice liability laws should provide adequate compensation for those who are truly injured while reducing frivolous lawsuits.

I firmly believe that it is a principle of any case, including patients against insurance companies, that people who are harmed ought to be made economically whole. But there has to be a balance between frivolous lawsuits and making sure that people can be made whole if harmed.

I think the Kennedy-McCain bill fails to strike that very carefully needed balance and instead creates a lottery for trial lawyers, which not only inflates the cost of health insurance for all of us but also leads to more and more hard working Americans losing health coverage.

We shouldn't do anything in this bill that will cause people to lose their health insurance. We already have 42 million uninsured Americans. The best opportunity for affordable health insurance as well as coverage is in employer-related health insurance programs.

Don't forget that we have over 50 million insured Americans under the self-insured plans that employers offer. The case is that most of these self-insured plans come from small business more so than large corporations. We should not be putting these employers and their employees in a situation where that employer, because of the threat of suit under this bill and losing a generation and a lifetime of savings in that family business, will not want to take a chance of losing his investment which has been built up through a family working together and investing everything back into the business because of a threatened lawsuit. If that is a threat, then you can understand why the employer might just eliminate their self-insurance and in the process throw the employees into a situation of having no health insurance, resulting increases in the number of 42 million people in this country who now do not have such insurance.

Here is how I believe this will inflate costs, and thus cause employers and

employees to not have health insurance coverage. Except for the $5 million cap that is in this bill on punitive damages in Federal courts, the Kennedy-McCain bill sets absolutely no limits on what damages trial lawyers can collect.

When it comes to patients and those harmed because of lawsuits, it ought to be an axiom of all of our public policy that the people harmed, not lawyers, should get most of the money from a lawsuit.

Of course, the Bond amendment then makes this more true than under the existing practice. You have to consider that trial lawyers generally collect 40 percent of their clients' recoveries. In fact, in many cases, you can have the lawyer's fees plus other court costs work out to where the person harmed is getting less than 50 percent of what the jury might award.

Trial lawyers generally collect 40 percent of their clients' recoveries. Incentives for bringing cases regardless of merit are then extremely high. It is a perverse incentive to go to court and to go to trial.

But the real jewel in the trial lawyer's crown is this bill's provision that allows the same suits for the same claims brought by the same trial lawyers, whether they proceed in State or Federal courts.

Even though this debate is supposed to be about patients, the Kennedy-McCain liability scheme isn't about patients at all. It is about trial lawyers. In fact, as you can see, I call this the ''trial lawyers lottery ticket.'' I want to show where five out of six opportunities for monetary awards are virtually jackpots for lawyers.

Take a closer look. I would like to just scratch the trial lawyer's lottery ticket and see what the lawyer gets. Let's start with medical costs.

Peel off the lottery ticket top, both for State court and Federal courts, you will see ''bingo''—no limit on what trial lawyers can collect in both State and Federal court. That is a jackpot that ought to make any lawyer happy.

But why quit when you are ahead? Let's take a look at what is in store on pain and suffering. Peel that lottery ticket, and you can see what you get on pain and suffering. It is another jackpot—unlimited damages in State and Federal courts.

The sky is the limit. That is where the trial lawyers are really winning big.

Now, for the trial lawyer's favorite damages, punitive damages, they stand to reap tens of millions of dollars.

Let's see what this ticket offers the trial lawyers. So we pull off the punitive damages square. You can see: unlimited damages in State court, and up to a $5 million cap in damages as far as the Federal courts are concerned.

This is another big win. Talk about good luck: unlimited punitive damages in State courts, and in the Federal courts almost unlimited—a $5 million cap. If you ask me, that is hardly any limit at all.

Mrs. BOXER. Will the Senator yield for a question?

Mr. GRASSLEY. No, I will not. I only have 10 minutes. And we lost some other time on this situation of waiting for the leader.

Mrs. BOXER. On my time. I would ask a question on my time.

Mr. GRASSLEY. Finally, if I could, let's not forget about class action lawsuits where multimillion-dollar damages are the name of the game. So here again we peel off the lottery ticket. You can have class action lawsuits in State courts. You can have class action lawsuits in Federal court.

So bingo again. Kennedy-McCain has no limits on class action lawsuits. It even creates new grounds for bringing class action cases.

As you can see, everybody wins—every lawyer, that is—with the trial lawyers' lottery ticket.

What we get back to then is that we are more concerned about treatment for trial lawyers, not treatment for patients. It seems ironic that the very individuals this bill claims to protect are the ones who lose. Despite what its sponsors say, the bill before us exposes employers to the constant threat of litigation, even for simple administrative tasks and clerical errors.

What is the ultimate result? What everybody says they do not want to ever happen. People lose coverage. When this sort of perverse incentive is out there to threaten small business, particularly those that are self-insured—because they do not want to put in jeopardy their lifetime of work but want to create jobs, so they can be part of the community, so they can have good workers and pay their workers well—and, most importantly, workers want good fringe benefits; and the No. 1 fringe benefit they want is health insurance—it puts it in jeopardy employer-based coverage. Then the ranks of the uninsured go up tremendously.

I yield myself 1 more minute.

Mrs. BOXER. Reserving the right to object, I would ask for 1 minute as well upon the conclusion of the Senator's remarks.

Mr. GRASSLEY. I object to that. There is plenty of time on that side for the Senator to take her time. I am taking time off our side.

Madam President, how much time do I have left?

The PRESIDING OFFICER. There are 3½ minutes left for the sponsor.

Mr. GRASSLEY. I would like to take 1 minute of that 3½ minutes.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. So the ranks of the uninsured are going to go up. There are 42 million uninsured now. Do we want to increase that? No, nobody wants to increase that, but that is going to be the end result when these self-insured plans are dropped. Then, of course, the employees become the biggest losers in this lottery.

So I urge my colleagues to reject this lottery and to support the Bond amendment, which creates much needed patient minimums and ensures that patients, not lawyers, get fair compensation for their losses.

I reserve the remainder of the time and yield the floor.

The PRESIDING OFFICER. Who yields time?

The majority leader.

Mr. DASCHLE. Madam President, I will use my leader time and not take any time off the agreed-upon time allocated for the amendment.

Madam President, I would just say on the amendment, there is nothing in there that would limit the lawyers' fees for the insurance industry. Those are unlimited. While they limit the legal fees for lawyers defending patients, there is nothing to limit the legal fees for lawyers defending HMOs and insurance companies. I find that quite ironic.

SUPPLEMENTAL APPROPRIATIONS

Madam President, I want to propound a unanimous consent request. I will not do that at this time because I have been talking with the distinguished Republican leader. But I want to propound a request, as I had indicated I would, to lock in the debate for the supplemental.

There are a number of amendments that have been suggested. I know the unanimous consent agreement has been cleared on our side now for I think 3 days. We have been unable to get consent from our Republican colleagues for the last 3 days.

Now I am told they may object to even going to the supplemental, at least initially. If that happens, of course, I will be forced to file a motion to proceed. But I think it is important.

There was a story in the Washington Times dated June 26, and I think for the RECORD it would be helpful if I just read it because I think it does capture the urgency with which we address the supplemental. So I will take just a moment to read it:

The U.S. military would be forced to curtail or cancel training exercises, facility repairs and equipment maintenance if Senate Majority Leader Tom Daschle holds up a pending emergency budget until late July, according to Pentagon projections.

The Pentagon provided a list of hardships at the request of Senate Minority Leader Trent Lott. He used the list yesterday to criticize Mr. Daschle for threatening to delay action on a $6.5 billion supplemental budget bill until the Senate completes work on a contentious patients' bill of rights. That delay would push approval of the fiscal 2001 defense legislation until late July or beyond.

''If we don't get this bill completed by . . . mid-July, we're going to have canceling of base-property maintenance, [and] holding some of our deployed units where they are overseas until the end of the fiscal year,'' said Mr. Lott. ''So we're really pushing the envelope when it comes to the needs of our military personnel in health as well as in steaming hours.''

Picking his first confrontation with Democrats since they took control of the Senate, Mr. Lott also accused Mr. Daschle of sacrificing the nation's urgent energy needs in order to push through the health care bill. . . .

Nearly all the budget bill's funding goes for replenishing military training accounts depleted by peacekeeping missions in the Balkans and elsewhere. Without emergency funding soon, the military will be forced to:

Curtail all nonessential operations such as pilot training, steaming hours, fleet exercises, and air combat training maneuvers. The Air Force and Navy would ground some pilots and aircraft.

Perhaps hold deployed units overseas until the new fiscal year begins October 1.

Cancel training for units getting ready to deploy for peacekeeping duties.

Stop or slow down maintenance of equipment at large regional depots.

''This will lead to the loss of jobs for many Americans,'' Mr. Lott's office said.

The Joint Chiefs of Staff originally wanted about $9 billion in [requests].

Madam President, I ask unanimous consent that the entire article be printed in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From the Washington Times, June 26, 2001]

DASCHLE DELAYS; MILITARY WAITS

PENTAGON NEEDS EMERGENCY FUNDS

(By Rowan Scarborough and Dave Boyer)

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''If we don't get this bill completed by . . . mid-July, we're going to have canceling of base-property maintenance, [and] holding some of our deployed units where they are overseas until the end of the fiscal year [Sept. 30],'' said Mr. Lott, ''So we're really pushing the envelope when it comes to the needs of our military personnel in health as well as in steaming hours.''

Picking his first confrontation with Democrats since they took control of the Senate, Mr. Lott also accused Mr. Daschle of sacrificing the nation's urgent energy needs in order to push through the health care bill.

Neglecting energy and defense has ''very dangerous implications for the security and prosperity of the American people,'' the Mississippi Republican said.

Nearly all the budget bill's funding goes for replenishing military training accounts depleted by peacekeeping missions in the Balkans and elsewhere. Without emergency funding soon, the military would be forced to:

Curtail all nonessential operations such as pilot training, steaming hours, fleet exercises and air combat training maneuvers. The Air Force and Navy would ground some pilots and aircraft.

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''This will lead to the loss of jobs for many Americans,'' Mr. Lott's office said.

The Joint Chiefs of Staff originally wanted about $9 billion in emergency funding in January. But incoming Defense Secretary Donald H. Rumsfeld nixed the request. The White House scrubbed the numbers and presented the $6.5 billion proposal. The House already has approved that number, as did the Senate Appropriations Committee.

Mr. Lott said he suggested the Senate OK the emergency defense bill by unanimous consent, since both chambers approved Mr. Bush's list of spending requests without adding home-state projects, as was the practice with supplemental bills the past few years. But Mr. Lott said Mr. Daschle, South Dakota Democrat, rejected that idea.

Mr. Dashle, despite earlier indications that he would allow a speedy vote on the spending bill, told colleagues Friday that he would not bring it to the floor until the Senate completes work on a patients' bill of rights.

Republicans have been slowing down final passage of that legislation, raising concerns about employer liability and increasing premiums. Their tactics could derail Mr. Daschle's stated goal of finishing the bill by Friday.

The fate of the health care bill is particularly sensitive for Mr. Daschle because it is his first test of his ability to move legislation since becoming majority leader. Senate committees remain unable to take up new legislation due to prolonged negotiations between the parties on how to reorganize and whether to guarantee votes on Supreme Court nominees.

Daschle spokeswoman Molly Rowley said Mr. Daschle wants to complete the patients' bill of rights, the spending bill and the reorganization before the Senate adjourns for the Fourth of July recess.

''We think all three of these things can be done this week before we leave,'' she said.

Sen. Robert C. Byrd, West Virginia Democrat and chairman of the Appropriations Committee that approved the spending bill last week, said yesterday he was ''not in a position to comment'' on Mr. Daschle's intentions.

''The leader has to balance a lot of things,'' Mr. Byrd said, ''I'm sure he'll get to the [spending bill] when he thinks he can.''

Mr. Lott said Mr. Daschle rejected his suggestion to approve the spending bill by today, making it unlikely that a conference bill could be worked out before the House adjourns Friday for a weeklong Independence Day vacation.

''We need to get this defense and other issues supplemental done before we leave, because it is critical for nonessential operations like pilot training, steaming hours, fleet exercises,'' Mr. Lott said, ''I'm very worried that by not acting this week on the defense supplemental appropriations bill we're asking for more delay and even more problems with our defense needs.''

Mr. Daschle has been threatening to cancel the Senate's vacation to compel Republicans to finish work on the health care bill.

Republicans and Democrats have been sniping politely about legislative priorities ever since the power shift in the Senate. Republican lawmakers have been pressing for passage of President Bush's energy plan, but Mr. Daschle has expressed more interest in the health-care legislation, as well as increasing the minimum wage and passing a hatecrimes bill.

Mr. Lott said yesterday that Democratic leaders do not intend to address the energy issue by the end of July.

Congress is in recess for the entire month of August, meaning the Senate would not take up the administration's energy plan unitl September at the earliest.

House and Senate Republicans met with White House representatives late yesterday and agreed to call attention to Democrats' inaction on an energy plan over the recess next week. The meeting took place in the office of House Majority Whip Tom DeLay, Texas Republican.

Mr. DASCHLE. Madam President, Senator STEVENS and Senator BYRD came to me a couple of weeks ago and asked for a special exemption from the understanding we have been working under here in the Senate that no official action can take place on any legislation until we have broken the impasse on the organizing resolution and assigned each committee its full complement of members. I, of course, agreed, in the interest of urgency, to allow the Appropriations Committee to work its will and to finish this supplemental, which is what it did. I applaud both of them for taking the action they did.

The House, of course, has now acted. Now it is up to us. A couple of days ago the President called me and said: Above all, I hope that you will pass the supplemental before you leave. I gave the President my personal assurance that we would pass the supplemental here in the Senate before we leave.

Now I am told that there are some who would prefer to take vacation rather than finish the work. Madam President, we can't do that. We can't take vacation until the work is done. We can't take vacation until the Patient Protection Act is done. We can't take vacation until the supplemental is done. We can't take vacation until the organizing resolution is done. It is as simple as that.

I will propound a unanimous consent request at a later time because I know Senator STEVENS wanted to come to the floor. We have been working through this. As I say, I thought we had an agreement. In fact, I was told we were able to propound the request an hour or so ago. Unfortunately, that report apparently was in error.

I am going to do what we have to do, in part because as Senator LOTT has said so clearly—and forcefully—the alternative to not acting is to risk what the Washington Times has reported, to wreak havoc with the military, to keep them from getting their job done, to actually endanger our military personnel in some ways. We are not going to be accused of endangering the military. We have to do what the President, the Commander in Chief, requested. That is what we are doing here.

We will offer the unanimous consent request to proceed. If that fails, I will file a cloture motion on the motion to proceed, and when it ripens we will have the vote. But we will have the vote.

Mr. DORGAN. Will the Senator from South Dakota yield?

Mr. DASCHLE. I am happy to yield.

Mr. DORGAN. I ask the majority leader, isn't it the case that the three issues that are outstanding—finishing the Patients Protection Act, passing the supplemental, and the organizing resolution—could be done rather quickly? We have, after all, been debating

the Patients Protection Act for some long while. We have gone through most of the major amendments. We started debating this issue 5 years ago. It has now been on the floor for some while. We have done most of the major amendments. If we could complete the Patient's Bill of Rights later today we could move on to other business. I am a member of the Appropriations Committee. When we passed the supplemental bill, it was passed almost with no amendments in the House of Representatives; that bill is very important—we did it with very little debate in the full Appropriations Committee. The organizing resolution can be completed, I understand, with perhaps one vote.

It is the case, isn't it, that all of this could be done perhaps this evening if we had cooperation? Is that not the case?

Mr. DASCHLE. The Senator is correct. As I understand it, this bill was not subject to amendment in the House. It passed overwhelmingly in a very short period of time. I don't know why we would have to elongate or unnecessarily prolong the debate on this side.

Whatever length of time may be required to consider this bill, we will do that. All I am saying is that we have to do it before we leave.

I see both the ranking member of the Appropriations Committee and the distinguished Republican leader are on the floor.

I ask unanimous consent that the majority leader, following consultation with the Republican leader, may proceed to the consideration of Calendar No. 76, S. 1077, the supplemental appropriations bill and that the bill be considered under the following limitations: That only first-degree amendments in order other than a managers' amendment be the following list which is at the desk—I won't read the list at this point—that any listed first-degree amendment be subject to relevant second-degree amendments, that any time limitation for debate on a first-degree amendment be specified in this agreement; then any second-degree amendment to that amendment be accorded the same time limit; that upon disposition of the above amendments, the bill be advanced to third reading; the Senate then proceed to the consideration of Calendar No. 77, H.R. 2216; that all after the enacting clause be stricken and the text of S. 1077, as amended, be inserted in lieu thereof; that the bill be advanced to third reading, and the Senate then vote on passage of the bill with no intervening action or debate.

Finally, I ask unanimous consent that S. 1077 be returned to the calendar.

The PRESIDING OFFICER. Is there objection?

Mr. LOTT. Reserving the right to object, Madam President.

The PRESIDING OFFICER. The Senator from Mississippi.

Mr. LOTT. First of all, I think it is important that we dispose of this issue as quickly as possible so that we can get back to the debate on the amendments that are pending. There are still a number of very important amendments that Senators wish to offer with regard to the Patients' Bill of Rights. I know the Senator from Nevada has been working on this issue and knows that. These are substantive and important amendments.

When it was suggested by the Senator from North Dakota that most of the major amendments have already been offered and considered, I don't believe that is accurate. Of course, I guess how important they are is in the eye of the beholder or the offeror of the amendment. I think it is important that we address this issue and get back to having debate and hopefully votes this afternoon and into the night, however long it takes to deal with important issues that still need to be addressed.

We still believe very strongly that this bill has not been corrected in terms of its major problems in the likelihood of loss of coverage and increased premiums, and when, how, and where lawsuits are going to be filed instead of making sure patients get the health care coverage they need. We can resolve this relatively quickly and then go back to that.

With regard to the organizational resolution, we continue to exchange ideas. I think it is possible that it could be handled with only one vote, or it may take three, but we are hoping we can get that worked out. I know there are a couple of letters that are being reviewed now on both sides that might make it unnecessary to have three recorded votes. I think we are going to have two letters dealing with the question of public disclosure of the blue slips which can be used by Senators to block a judicial nomination. There is a strong belief on both sides that those should be made public and not just handled secretly, as has sometimes been the case but not always the case, in the past.

Also, we are looking to see if we can get some agreement in writing that we would continue to do what the precedents are with regard to Supreme Court nominees. I believe going back all the way to 1881, the whole Senate has voted on Supreme Court nominees even when the committee has voted on a tie or negatively. But we are working on that, and I would like us to get that resolved in the next 24 hours myself.

With regard to this unanimous consent request, I had really hoped we could do it Monday. I thought it could have been, I believed it could have been done Monday in a very limited period of time without this rash of amendments. I think we could have gotten an agreement that there be no amendments. That didn't happen for whatever reason.

Senator BYRD and Senator STEVENS had indicated they would like to have done it even last night so that we could have done it quicker and so we could perhaps have gotten into a conference with the House. The problem now is that if we don't take this up immediately, right now, we are not going to be able to get a conference agreement. There is no chance of a conference agreement until after the Fourth of July recess, even if the Senate should act sometime tomorrow or Saturday. I really had hoped we could do it earlier so we could get into conference, get it completed, and send it to the President. That now appears not to be likely, unless the Senate wants to turn right now to consider this very important supplemental appropriations resolution. I would like that to be considered.

Failing that, I think we are not going to object to agreeing to this unanimous consent request, but there are 35 amendments now—34 or 35. Some of them clearly are important to Senators involved on both sides of the aisle. Senator BOND has a couple of them. Senator BOXER has one I think she probably feels very strongly about. Senators CLELAND, ROBERTS, and others have amendments with regard to the B–1 bomber. Senator CONRAD, I haven't talked to him, but he has one on Turtle Mountain Indians. As you look down the list, some of them are not just relevant, some of them are amendments about which Senators are going to care greatly. And it looks to me as if you are talking about an extended period of time at this point to complete action on this legislation. I regret that.

If we could get an agreement to go to it now—I see Senator MCCAIN; I know he has an amendment he feels very strongly about—if we could do that now, maybe we could get some time agreements and move to completion.

I see the distinguished Senator from Alaska, the senior member of the Appropriations Committee on the Republican side, who wants to speak. I am glad to yield under my reservation, Madam President.

Mr. STEVENS. Madam President, I am here to urge that the Senate take the bill up now. I think if we took it up now, working with the people who have those amendments, we ought to be able to finish it today. I think if we finish today, the House will stay, and we could complete this before the recess. If we wait until Monday after the House has already gone home, it will be very difficult to get them back, even from the point of view of getting travel arrangements for the House to come back on Monday or Tuesday.

I cannot speak for the chairman, but I can say that we both have sought for the last 2 weeks to try to have this bill become law in time to meet the needs of the armed services. Very clearly, they have been demonstrated now. There is no question that if we do not get this bill passed, there is going to be an impact on the armed services. I will commit myself to both leaders to work with all Members to see what we can work out, to constrict the time and finish it tonight, if we can take it up now.

That might put pressure on the other bill, too.

I urge that the organization resolution get resolved. I personally say to both leaders, my Kenai Peninsula is on fire. That is where I want to go fishing next week, too. So there is a disaster and the urgent call of the pink salmon to respond to.

I pledge myself to work even harder than Senator REID does to find some way to constrict this time so we can vote on this and get it to the House and bring it back so we can all vote on the bill before we go home. I plead with the leaders to let us have the reins for a few hours and see what we can do. I think we can finish this bill tonight.

Mr. LOTT. Madam President, under my reservation, I will propound as an alternative unanimous consent agreement the same proposal the majority leader has made, except that in the first paragraph under consultation with the Republican leader, I would add ''may proceed immediately to the consideration of Calendar No. 76, S. 1077.'' I make that in the form of a unanimous consent request.

The PRESIDING OFFICER. Is there objection?

Mr. DASCHLE. Madam President, reserving the right to object, I have offered this to our Republican colleagues now for several days. I have said, give me a definitive list that will allow us to finish our work on the Patients' Bill of Rights. We will proceed immediately to the supplemental, finish it, and then return to the Patients' Bill of Rights with the understanding that we will complete work on that as well.

Unfortunately, our Republican colleagues have been unable to do that. My offer still stands. Give me a definitive list that we can complete before we leave, and I will go immediately to the supplemental. I have offered it privately to Senator LOTT. I have offered it to our other colleagues. That offer still stands. Until we get that assurance, I will object.

Mr. LOTT. Under my reservation, I have one inquiry. I thought we had a definitive list. It may be big, but I thought we had a list of amendments still pending out there.

Mr. DASCHLE. I have not seen it.

Mr. LOTT. We will work on that.

The PRESIDING OFFICER. Is there objection to the original request?

Mr. REID. While the two leaders are here, if I may chime in, first of all, Senator DASCHLE has read the importance of this supplemental. If it is as important as has been read into the RECORD, it would seem to me the House should hang around a little while longer.

I say to the Republican leader and our majority leader, I haven't seen a list of amendments. Everybody knows we have just a few important amendments to finish the Patients' Bill of Rights. If we are given a list of amendments that is large in number, I don't think that is in keeping with what I think should be the general agreement to finish the legislation. If we are given a list of 10, 20, 30, 50 amendments, I suggest to the majority leader, that is not part of the deal. We have a few amendments left to go.

Mr. LOTT. If Senator DASCHLE will yield to respond briefly, I thought you had been given a list. I am going to make sure you have it and then we can evaluate that and work on it.

Mr. DASCHLE. Madam President, I offer a unanimous consent request that the Senate complete its work on the Patient Protection Act by 6 o'clock tonight, and we have final passage by 6 o'clock tonight. If we can agree to that right now, I will move to the supplemental at 12 o'clock this afternoon.

Mr. LOTT. Madam President, I object to that. Obviously, I have to consult with the managers of the legislation on our side about the amendment list, which is very long, and I have it now, and about what is possible in terms of completing it. I don't think it is possible at all to set an arbitrary time, in view of the very serious amendments that are pending on the Patients' Bill of Rights. So I object to that request.

The PRESIDING OFFICER. The original request of the majority leader is still pending. Is there objection?

Mr. STEVENS. Reserving the right to object, Madam President, I am constrained to say with due respect to the leader and the majority leader and majority whip, I find it very difficult to deal with the concept putting ahead of this supplemental the completion of two very controversial items. We know the House is going home, and having spent 8 years here on the floor as leader, I can tell you I have never seen the time when any Senate could dominate the House. We have a bipartisan agreement to go home. They have told me they will stay if we get this bill done and over there today.

I do believe that the interest of national defense should come ahead of concepts that we are dealing with here in terms of whether it is the Patients' Bill of Rights or organization of the Senate. We know people will be told they cannot train in July and August unless we get this bill done this week. It is not something on which we have been dilatory. We have been trying for a long time.

I have great respect for the leader and the assistant leader, but I cannot stay silent and have a concept that because the leader has stated these things must be done, they must be done before the supplemental is brought up. That is unacceptable to this Senator. I think it is unacceptable to the Senate. I hope it is.

I say with great humility now that the needs of our people in the armed services must come ahead of concepts of scheduling or prerogatives here on the floor. These needs are very real. We have twice held hearings now where the chiefs have told us what is going to happen if this bill is not signed by the President before the Fourth of July.

Even the concept of taking up and passing it now and letting it wait for the House to come back is unacceptable to me because, again, we all travel and we know you can't let the House go home and expect they will come back here on July 3 just before the Fourth of July. You can't travel in this country that easy during that period.

So I plead with the Senate, let us proceed with this bill. We should put aside all other desires. There is no timeframe on the Patients' Bill of Rights that matters to this country. It is a bill that must be passed, and I am going to vote for it. But it does not have the urgency of this supplemental.

This supplemental deals with more than that. It now deals with matters that are emergencies coming out of the disasters that have happened in this country this spring.

I hope the leader will accept my comment that I mean no offense to him. I have served under several leaders, and I admire both Senator DASCHLE and Senator REID for what they are doing. But it is unacceptable to me to say no in terms of a request that has come on a bipartisan basis to put this bill aside for a few hours and pass a bill as important to the military of this country as is this supplemental.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. DASCHLE. Madam President, I remind my dear friend and colleague, the Senator from Alaska, in 1999, we took up the Patients' Bill of Rights under a unanimous consent request and passed it in 4 days, with 17 amendments. Now we are told we can't do it in 2 weeks. While we may differ on whether the supplemental is more or less important than the Patients' Bill of Rights, I would hope we could all agree that completing action before we leave on a supplemental dealing with the safety of our troops is a top priority. The Pentagon places an extraordinary priority on this legislation—so much so that the Commander in Chief called me to ask that it be done this week. Certainly we can agree it is more important than fishing or any other kinds of vacation we could be taking next week. While there may be some differences on other issues, I would think there would be unanimity that getting the supplemental done is more important than taking a vacation.

So that is what the issue is. We are not going to take a vacation until we have completed action on the supplemental. We are not going to leave until this is done. This is something that not only has been requested by the Pentagon but by the Commander in Chief as well; I would hope if the President makes additional calls, he will call the House and say: Don't leave until we get this done. You have heard the Pentagon. Don't leave until this is done. Vacations are secondary to work. We have to get it done.

I yield the floor.

The PRESIDING OFFICER. Has an objection been heard?

Mr. STEVENS. Reserving the right to object, that is a little bit of a cheap

shot. I am not talking about a vacation. I am willing to stay here as long as any other Senator. I am talking about the realities of the House. Leader, I am not going to forget that. That was a cheap shot, and for the time being, I object to the request.

The PRESIDING OFFICER. Objection is heard.

AMENDMENT NO. 831

The PRESIDING OFFICER. Who yields time on the amendment? The Senator from Missouri.

Mr. BOND. Madam President, I reserve the remainder of my time. I believe there is more time on the other side. I want to give the other side their remaining 19 minutes, but I believe we only have 2 minutes. I reserve those 2 minutes for the end of the debate, and I do have a couple of minutes after they have had an opportunity to present their case.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Madam President, with the consent of Senator KENNEDY, I yield myself such time as I may consume, recognizing the Senator from North Dakota wishes to be recognized. I will not take long.

Many years ago, before I came to Congress, I practiced law. I was a lawyer. I was a trial lawyer. I am very proud of that fact.

With that brief background, I received a call last night from a lifetime friend. I have not talked with him in a while, but we went to high school together. We played ball together. We were inseparable friends. He did not have my phone number. I had moved. He called my office and said it was urgent.

He called because his son was in trouble. Why? Because they had hired a cheap lawyer. His son was in trouble, and they hired a cheap lawyer. The young man is now in jail.

My friend from Missouri is a lawyer, a fine lawyer, I am sure. I refer to the pending amendment as the ''cheap lawyers amendment.'' You cannot find decent lawyers to take a case for 15 percent. Almost 50 percent of the cases in our Federal court system take 4 years to litigate, with files stacked as high as my desk. People work to prepare those papers representing people who are injured, hurt, and need an attorney. That is why we have contingent fees. It is hard to find lawyers to take even a good contingent fee case because they have to consume so much time and effort.

Of course, there are some people who are paid too much, I am sure, because they put in the time and it is a contingent fee. I sold my home in Virginia within the past year. The woman who sold my home was a good realtor. I tried to find the best I could. I signed a contract with her. She made a ton of money on my home. She worked about a week. I don't know, but she probably took a lot of time off during that week. My home sold in a week. She made a lot of money for the few hours she spent on my home, but that is the way America works.

If we have people who need help, we need to have the full panoply of lawyers available so they can get a good lawyer.

My friend from Iowa had a chart and peeled off medical bills: These people are going to get their medical bills. Well, isn't that too bad. If someone does something wrong, should they not pay your medical bills? Do you need to have a lotto, as he says, a lottery to get your medical bills paid? I hope not.

We have heard mentioned several times, if we are concerned about attorney's fees, how much are these attorneys for these big HMOs making to prevent people from getting medical care? Let's take a look at that.

We talk about these cases in the abstract, but the fact is that attorneys, whom everyone wants to hate, are necessary; they help. I am proud of the fact I was a lawyer. I have four sons. Every one of them is a lawyer, and I am proud of the fact that they followed in the footsteps of their father. My daughter is a schoolteacher. She married a lawyer. I am very happy for that.

We do not have to be shameful, concerned, or embarrassed about some lawyers getting paid a contingent fee. That is how people who are injured and hurt are allowed to take those cases.

Fifteen percent will discourage representation by good lawyers. My friends on the other side of the aisle talk about the sanctity of contracts. Why do we want to step in and tell States what lawyers can be paid based on a contract they get?

This amendment is only to protect HMOs, as all the other amendments from the other side, to try to derail this legislation. This amendment is a frivolous amendment. It has nothing to do with the merits of this legislation.

Mr. DORGAN. Mr. President, will the Senator from Nevada yield?

Mr. REID. I will be happy to yield to my friend from North Dakota.

Mr. DORGAN. The Senator from Nevada and I had a brief discussion previously about this issue. He is correct that this amendment attempts to limit the ability of patients to hold HMOs accountable.

The discussion by those on the other side who have offered this amendment talks about lawyers in a pejorative way on behalf of patients. Does the Senator know of any attempts by those who have offered this amendment to limit HMOs, managed care organizations, from using lawyers, or is this just saying we will limit patients from using an attorney to go after a managed care organization that did not provide the care they promised, but we will not limit managed care organizations from using attorneys to do whatever they want to do?

Mr. REID. Madam President, I answer as follows: Of course, there is nothing in the way of amendment to limit what attorneys for these wealthy, big, sometimes brutal HMOs are paid. But remember, I say to my friend, that people who are seeking help from a lawyer are looking for a lawyer who will do it not on an hourly basis but who will do it on what is called a contingent-fee basis. They have no money to hire one of the big HMO lawyers, so they look around and find somebody who will take their case on a contingent-fee basis.

I say to my friend, a 15-percent contingent fee will not get a good lawyer. It will be like my dear friend who called me last night. In effect, the client will not wind up in jail but will end up with no compensation.

Mr. DORGAN. I ask my friend from Nevada to yield further for a question.

Mr. REID. I will be happy to yield to my friend for a question.

Mr. DORGAN. Is it not the case that this entire process, this debate on the Patient Protection Act, is an attempt to balance things a bit; that patients do not have the ability to confront a big managed care organization?

The Senator from Nevada knows the story we have talked about coming from his State: Christopher Roe, a circumstance where a 16-year-old boy was fighting cancer at the same time he was fighting his managed care organization for treatment and care he needed. That is not a fair fight, asking a young boy to fight an insurance company and fight for his life at the same time. That young boy lost his life on his 16th birthday.

The question is, Do those patients and their families have the right to get an attorney to hold the managed care organization accountable to deliver the care they promised? Do they have that right?

We have an amendment pending that says: No, we are going to limit the rights of the patients, we are going to limit the rights of citizens, but we are not interested in limiting the rights of the managed care organizations because we want to stand for them rather than standing for patients, and that is the issue.

Mr. REID. In answer to my friend, I have a CRS report that talks about awards of attorney's fees by Federal courts and Federal agencies. It is big. I know of no other Federal attorney fee statute that affects a State system.

This amendment is wrong. I appreciate very much my friend from North Dakota, who is not a lawyer, standing up and speaking for the injured people and the potentially injured people of America.

Mr. KENNEDY. Madam President, I ask for 3 minutes.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Madam President, I rise in opposition to the amendment that has been offered. We have seen the efforts of the HMOs to undermine this legislation in different ways over the last few years. We were unable to bring this matter up for consideration by the Senate and get full consideration of the bill when we wanted to. This happened

even during the last term when a majority of the Members would have supported a good, tough, effective Patients' Bill of Rights. We have seen over the past days constant efforts to undermine this legislation.

We see another effort to try to appeal to the Members about the excessiveness of decisions made in the courts to reimburse individuals in terms of wrongdoing by other industries.

The fact is, as we are reminded by our colleagues, we have spent 3 days talking about the sanctity of the contract between the HMO and the patient. We have had amendment after amendment saying, look, this is enormously important. We do not want to permit any changes in that contract. We want to stick with that contract. We want to hold to that contract. Now with the Senator's amendment we are saying basically that we are going to ride roughshod over contracts that are decided, permitted, and authorized by law in the States between attorneys and their clients.

I have listened a great deal to talk about how Washington doesn't know best; how we don't want just one solution to solve all of our problems. We had that debate early this morning and last night. We now have one solution: to override States in terms of what decision the States make for compensation going to court.

The fact is, how many working families, and how many middle-income families are going to be able to go out and hire lawyers? For the time it will take to get some kind of recovery after they have been wronged, how many are going to be able to do that and follow this through the State courts? How many will be able to do it after they have been hurt, after their child has been disabled, after a wife or husband has been killed? How many? Very few. The fact is, they are not going to be able to be compensated unless they are able to convince a jury they are right, that there has been wrongdoing.

Does that bother people in the Senate? Evidently it does. There are only a very few Americans who can afford the high-priced lawyers to go into court and pursue this. This amendment undermines it for the rest of the people. It undermines it for working families, undermines it for middle-income families. That is the record. That is what has been done.

It doesn't surprise me. We have seen the powerful special interests overturn ergonomic regulations which were there to protect working families. Then we have the undermining of funding for the enforcement for protecting our air. There has been undermining of funding for protecting OSHA, effectively cutting back on the protection of workers. We are undermining regulations to protect workers, undermining the enforcement mechanism to protect consumers, and now they want to take this right away from individuals who will be harmed because of HMOs.

It is a common pattern. It is all targeted by the major financial special interests versus the consumer. That is what this is about. They don't like to hear about it. They keep offering amendments that are couched in other language about all the people that will be unemployed. However, it is the power of the HMOs against the little guy.

This amendment says the little guy will not be able to defend their interests in court. That is what this is about.

Make no mistake. They can't deal with us in giving protections to the consumers. They are going to take them away by denying them the rights to enforce them. That is what this is about.

Expect that after we have this percentage, it will go a little higher, and then try to go even higher. Every time it does, it is an insult to middle-income and working families and individuals who will be harmed. Make no mistake, it is another assault on the fundamental protections of this act. That is what this amendment is about. I hope it will be defeated.

The PRESIDING OFFICER. Who yields time?

Mr. BOND. How much time remains?

The PRESIDING OFFICER. The Senator from Missouri has 3 minutes.

Mr. BOND. I want to respond. Does the other side desire more time?

Mr. KENNEDY. I don't think so. It depends on what the Senator says. We don't intend to at this time.

Mr. BOND. How much time remains on the other side?

The PRESIDING OFFICER. Five and a half minutes.

Mr. BOND. I yield myself the remaining time. I think some of the things that have been said deserve to be answered.

Our efforts are not to undermine a bill but to deal with very bad provisions in the bill which skipped the committee, did not go through committee markup. We are marking up a bill now which we should have marked up in committee. It has come to the floor and we are a committee of the whole.

There are things that are in there that are very bad for patients, employees, particularly of small business. Why are we inserting the Federal Government into restricting attorney's fees? The States in this Nation have limited attorney's fees because they recognize the abuses of the trial lawyers. Under this bill, we are inserting the Federal Government into areas that the States have already acted on, and they have acted on them and provided limits on the amount that trial attorneys can take so the injured party can recover.

We have heard about the powers of special interests. Let me state who the special interests are that have a big stake in this, the four top trial lawyer PACs: Trial Lawyers Association of America; Williams & Bailey; Ness, Motley; and Angelos Law Offices, have given over $8 million, more money than all the HMOs together have given in politics.

If you want to talk about special interests, there are special interests on the other side, as well.

We believe the measures we brought forth are good for employees, for people who not only want to be able to appeal the decision of an HMO, but they want to have health coverage.

Somebody suggests there have not been problems with fee structures. They are not in this bill. We know from the State experiences that there can be a tremendous amount of wasted money.

I urge my colleagues to support this measure.

I yield to my distinguished colleague from Tennessee.

Mr. FRIST. Madam President, I rise in support of the Bond amendment. This is a Patients' Bill of Rights and we should focus on the patient. We are talking about a patient who has been harmed or injured, gone through an appeals process and through the court. If there is a multimillion-dollar suit, it should be to help the patient, not to fund the pockets of the trial lawyers.

This is a Patients' Bill of Rights, not a trial lawyer bill of goods.

Mr. KENNEDY. Madam President, every time you pay the HMO lawyers, that comes out of patient protections. So the point is raised was, if you put a limitation on the trial lawyers because they are going to get the benefits, why not put a limitation on the attorneys for the HMOs so it doesn't come out of patient protections?

But they won't do it. They won't do it.

I yield the remainder of our time.

Mr. REID. What is the matter before the Senate now?

The PRESIDING OFFICER. Amendment No. 831.

Mr. REID. All time is yielded back?

The PRESIDING OFFICER. Time has been yielded back.

Mr. REID. I move to table the amendment, and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second. The question is on agreeing to the motion.

The clerk will call the roll.

The legislative clerk called the roll.

The result was announced—yeas 62, nays 38, as follows:

[Rollcall Vote No. 204 Leg.]

YEAS—62

| | | |
|---|---|---|
| Akaka | Conrad | Inouye |
| Baucus | Corzine | Jeffords |
| Bayh | Crapo | Johnson |
| Biden | Daschle | Kennedy |
| Bingaman | Dayton | Kerry |
| Boxer | DeWine | Kohl |
| Breaux | Dodd | Landrieu |
| Byrd | Domenici | Leahy |
| Cantwell | Dorgan | Levin |
| Carnahan | Durbin | Lieberman |
| Carper | Edwards | Lincoln |
| Chafee | Feingold | McCain |
| Cleland | Feinstein | Mikulski |
| Clinton | Graham | Miller |
| Cochran | Harkin | Murray |
| Collins | Hollings | Nelson (FL) |

| | | |
|---|---|---|
| Nelson (NE) | Schumer | Torricelli |
| Reed | Shelby | Warner |
| Reid | Specter | Wellstone |
| Rockefeller | Stabenow | Wyden |
| Sarbanes | Thompson | |

NAYS—38

| | | |
|---|---|---|
| Allard | Gramm | Murkowski |
| Allen | Grassley | Nickles |
| Bennett | Gregg | Roberts |
| Bond | Hagel | Santorum |
| Brownback | Hatch | Sessions |
| Bunning | Helms | Smith (NH) |
| Burns | Hutchinson | Smith (OR) |
| Campbell | Hutchison | Snowe |
| Craig | Inhofe | Stevens |
| Ensign | Kyl | Thomas |
| Enzi | Lott | Thurmond |
| Fitzgerald | Lugar | Voinovich |
| Frist | McConnell | |

The motion was agreed to.

Mr. KENNEDY. I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. WARNER. Madam President, I ask unanimous consent the order for the quorum call be rescinded.

Mr. REID. Objection.

The PRESIDING OFFICER. Objection is heard.

The clerk will continue the call of the roll.

The assistant legislative clerk continued the call of the roll.

Mr. WARNER. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection it is so ordered.

AMENDMENT NO. 833

Mr. WARNER. Madam President, in consultation with the managers of the bill, it has been indicated to me this will be an appropriate time for this amendment to be raised. I send it to the desk and ask that it be given immediate consideration. However, we have to set aside, as I understand it, the standing order with regard to the Snowe amendment. I first ask unanimous consent that it be set aside.

The PRESIDING OFFICER. Is there objection?

Mr. REID. Madam President, reserving the right to object—and I will not object—we have been in consultation for the last hour or so. Senator SNOWE of Maine is in the process of having her amendment drafted. She is a half hour away from being able to present something in writing that we can give to the Senator from New Hampshire. I have no objection.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The legislative clerk read as follows:

The Senator from Virginia [Mr. WARNER] proposes an amendment numbered 833.

Mr. WARNER. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To limit the amount of attorneys' fees in a cause of action brought under this Act)

On page 154, between lines 2 and 3, insert the following:

''(11) LIMITATION ON AWARD OF ATTORNEYS' FEES.—

''(A) IN GENERAL.—Subject to subparagraph (C), with respect to a participant or beneficiary (or the estate of such participant or beneficiary) who brings a cause of action under this subsection and prevails in that action, the amount of attorneys' fees that a court may award to such participant, beneficiary, or estate under subsection (g)(1) (not including the reimbursement of actual out-of-pocket expenses of an attorney as approved by the court in such action) may not exceed the sum of the amounts described in subparagraph (B).

''(B) AMOUNTS DESCRIBED.—For purposes of subparagraph (A), the amounts described in this subparagraph are as follows:

''(i) With respect to a recovery in a cause of action described in subparagraph (A) that does not exceed $100,000, the amount of attorneys' fees awarded may not exceed an amount equal to ⅓ of the amount of the recovery.

''(ii) With respect to a recovery in such a cause of action that exceeds $100,000 but does not exceed $500,000, the amount of the attorneys' fees awarded may not exceed an amount equal to 25 percent of such excess recovery above $100,000.

''(iii) With respect to a recovery in such a cause of action that exceeds $500,000, the amount of the attorneys' fees awarded may not exceed an amount equal to 15 percent of such excess recovery above $500,000.

''(C) EQUITABLE DISCRETION.—A court in its discretion may adjust the amount of an award of attorneys' fees required under subparagraph (A) as equity and the interests of justice may require.

On page 170, between lines 21 and 22, insert the following:

''(9) LIMITATION ON ATTORNEYS' FEES.—

''(A) IN GENERAL.—Notwithstanding any other provision of law, or any arrangement, agreement, or contract regarding attorneys' fees, subject to subparagraph (B), a court shall limit the amount of attorneys' fees that may be incurred for the representation of a participant or beneficiary (or the estate of such participant or beneficiary) who brings a cause of action under paragraph (1) to the amount of attorneys' fees that may be awarded under section 502(n)(11).

''(B) EQUITABLE DISCRETION.—A court in its discretion may adjust the amount of attorneys' fees allowed under subparagraph (A) as equity and the interests of justice may require.''

Mr. WARNER. Madam President, I will do something unusual. I am actually going to read the amendment myself such that colleagues and those observing floor operations from their offices can have a clear understanding of exactly what is in the amendment.

Further, I do not desire to consume a great deal of time in the debate because we have just had a very thorough debate on the generic subject of attorney's fees. Therefore, the Senate has pretty well framed in their minds the parameters in which they will or will not accept an amendment that has the effect of, in my judgment, preserving a reasonable amount of attorney's fees and at the same time allowing such awards as those attorneys obtain for their clients to be given; again, with the thought that it is a Patients' Bill of Rights and they have a right to get a reasonable amount of such recovery as is obtained from them.

I shall read from the amendment—it is very short—and say a few words, and then rest my case:

On page 154, insert the following: Limitation on award of attorneys' fees——

(A) In general.—Subject to subparagraph (C), with respect to a participant or beneficiary (or the estate of such participant or beneficiary) who brings a cause of action under this subsection and prevails in that action, the amount of attorneys' fees that a court may award to such participant, beneficiary, or estate under subsection (g)(1) (not including the reimbursement of actual out-of-pocket expenses of an attorney as approved by the court in such action)—

In other words, that would be awarded by the court without any restriction except to the court itself——

may not exceed the sum of the amounts described in paragraph (B).

The sums I am about to recite, we carefully researched all types of actions similar to this to get a scale of attorney fees which I felt was clearly reasonable.

(B) Amounts Described.—For purposes of subparagraph (A), the amounts described in this subparagraph are as follows:

(i) With respect to a recovery in a cause of action described in subparagraph (A) that does not exceed $100,000, the amount of the attorneys' fees awarded may not exceed an amount equal to one-third of the amount of the recovery.

In years previous to coming to the Senate and other various jobs, I was actually a member of the bar and practiced law. I was assistant U.S. attorney in a modest trial practice myself. That has sort of been a standard for many years in the bar, the one-third.

(ii) With respect to recovery in such a cause of action that exceeds $100,000 but does not exceed $500,000, the amount of the attorneys' fees awarded may not exceed an amount equal to 25 percent of such excess recovery above $100,000.

(iii) With respect to recovery in such a cause of action that exceeds $500,000, the amount of the attorneys' fees awarded may not exceed an amount equal to 15 percent of such excess recovery above $500,000.

(C) Equitable discretion.—A court in its discretion may adjust the amount of an award of attorneys' fees required under subsection (A) as equity and the interests of justice may require.

In other words, a judge may look at this fee schedule and decide, this particular counsel has done a great deal of work and, therefore, I believe I should raise his fee within the parameters of the section itself.

Further:

(9) Limitation on Attorneys' Fees.—

(A) In general.—Notwithstanding any other provision of law, or any arrangement, agreement, or contract regarding attorneys' fees, subject to subparagraph (B), a court shall limit the amount of attorneys' fees that may be incurred for the representation of a participant or beneficiary (or the estate

of such participant or beneficiary) who brings a cause of action under paragraph (1) to the amount of the attorneys' fees that may be awarded under section 502(n)(11).

(B) Equitable discretion.—A court in its discretion may adjust the amount of attorneys' fees allowed under subparagraph (A) as equity and interests of justice may require.

This amendment simply sets, in my judgment, a reasonable category of fees. I have tried, as best I can, not to tread, by virtue of States rights, on the right of the State to administrate its own bar and the like. I felt that discretion should be given to the trial judges, Federal and State, such as they can adjust that schedule of fees as they see fit.

The Senate, again, has, in a very thorough discussion under the Bond amendment, covered these issues and has in mind, again, its own framework wherein we can legislate on this matter by amendment or not legislate.

At this point, I yield the floor.

The PRESIDING OFFICER. The Senator from Arizona.

Mr. MCCAIN. Madam President, I thank the Senator from Virginia for his efforts. I think there is an agreement that there needs to be a cap on attorney's fees. It is my strong sense and belief that if we had a cap of 33.3 percent that applied to Federal and State courts, that would be accepted by the majority of this body.

What I worry about is us just going back and forth with escalating amendments. There are very few benefits of old age. One of them is to remember what happened in the past. When we were doing the tobacco bill, we had amendment after amendment, a series of amendments, on caps on lawyer's fees. It got a little ludicrous. We finally had a majority vote for $1,000 an hour. It was clearly not an effort at legislating, but it was an effort at some kind of political advantage. I know that is not the intention of the Senator from Virginia.

I hope that once this is debated and, if it is not accepted, that perhaps we could move to an amendment after Senator Snowe's amendment that would be around 33.3 percent, State, Federal court, end of it. That is going to make everybody unhappy, but I think it would be something that we could all support and then get this issue off the table and get to the very important issues such as resolution of exhaustion of appeals that Senators THOMPSON and EDWARDS are working on, liability issues. Senator FRIST has some important amendments, again, on liability issues, which we are narrowing down.

Hopefully, we can move forward. I thank the Senator from Virginia for his input.

Mr. WARNER. Madam President, if I might reply to my friend and colleague, there was no intention of the Senator from Virginia to repeat what is an historically important case on tobacco. I studied that case very carefully. There were, I think, three votes. My recollection is it was $4,000 per hour, at which time the Senate finally accepted. I would not participate in such a process. I just struck the one-third for the lower amounts of the recovery and basically scaled it to 25 and the other percentage as the rate of recovery increase. I would be happy to work with colleagues.

It goes to the question of just how much will be eventually given to the recipients who need these funds.

Mr. REID. Will the Senator yield for a question?

Mr. WARNER. Yes, of course.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. The Senator from Arizona and the Senator from Virginia are on the right track.

This amendment, with all due respect to my dear friend from Virginia, is really—we have another 15-percent limitation in here above a certain amount. I think that the most expeditious thing to do would be to set this aside, for the time being, and get some of the lawyers and nonlawyers to sit down and see if they can work out something acceptable to the managers. I am sure if it were acceptable to the managers, we could accept this.

I ask my friend from Virginia, who believes he has talked enough on this, that we withdraw this amendment, for the time being, in anticipation of working something out that is clear and more concise.

Mr. WARNER. That is exemplified by the leadership the Senator shows time and time again on this floor. I don't view this as a partisan issue. This is an honest effort by the Members of the Senate to recognize that individuals should be given their rewards and the attorneys should be given fair compensation. Therefore, Madam President, unless other Senators wish to speak at this time, I will——

Mr. MCCAIN. If the Senator will yield, I say to my colleague from Virginia, if the outcome of this amendment is not to the Senator's satisfaction, then I hope we can enter into negotiations that on a reasonable level—again, I just plucked 33⅓ percent because it is in there in one category, across the board, simple, two lines, and perhaps we can move on.

I know the Senator from Virginia, as well as the rest of us, doesn't want to be hung up on a series of votes that are iterations over the same issue. It seems that we can sit down and come to some reasonable agreement, which the other side of the aisle would strongly resist applying to State court, and this side would resist it on Federal court. It is something to have a substantial majority vote for. I hope the Senator agrees to enter into those negotiations.

Mr. WARNER. Madam President, I ask for the yeas and nays before I take the action.

The PRESIDING OFFICER. Is there a sufficient second?

There is not a sufficient second.

Mr. REID. Madam President, if the Senator really wants a vote on this, we will be happy to give it to him right now. I don't think it is the right thing to do. I suggest to the manager and my friend from Virginia, why don't we set this aside for a few minutes to see if we can work something out to get the matter resolved. I think as the Senator from Arizona indicated——

Mr. WARNER. I am agreeable. I ask unanimous consent that this amendment be set aside.

The PRESIDING OFFICER. Without objection, the amendment is set aside.

The Senator from Nevada.

Mr. REID. Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REID. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mrs. CLINTON). Without objection, it is so ordered.

Mr. REID. Madam President, it is my understanding, under the order that is in effect, we will go to the Snowe amendment with the purpose of offering the amendment under a 4-hour time agreement.

The PRESIDING OFFICER. The Senator is correct.

The Senator from Maine.

AMENDMENT NO. 834

(Purpose: To modify provisions relating to causes of action against employers)

Ms. SNOWE. Madam President, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Maine [Ms. SNOWE], for herself, Mrs. LINCOLN, Mr. DEWINE, Mr. NELSON of Nebraska, Mr. SPECTER, and Mr. MCCAIN, proposes an amendment numbered 834.

Ms. SNOWE. Madam President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The text of the amendment is located in today's RECORD under ''Amendments Submitted.'')

Ms. SNOWE. Madam President, I rise today to offer an amendment along with my colleagues Senator DEWINE, Senator LINCOLN, and Senator NELSON, who worked so hard, so diligently in crafting this compromise. Senator MCCAIN and Senator SPECTER are coauthors of this amendment as well.

The amendment we are offering today is designed to bridge the gap that exists between the supporters of the McCain-Edwards-Kennedy approach to employer liability in the Breaux-Frist-Jeffords bill.

I commend Senators MCCAIN, EDWARDS, and KENNEDY for their willingness as well as their patience to work with us on resolving the many issues that are associated with employer liability.

Everyone involved has had the same goal essentially, and that is to protect

employers from liability when they are not participating in making decisions concerning the health care of employee beneficiaries.

The discussion has really focused on how best to achieve that goal. This is an incredibly complex liability issue that has far-reaching consequences, and everyone who has been part of this discussion and this effort to reach this consensus recognizes that fact and has worked in good faith to arrive at a solution that we can live with and, more importantly, employers can live with and not denying care that patients rightly deserve.

This is an issue that is significant on a number of different levels. First of all, to what extent will employers that voluntarily offer health insurance be exposed to liability. To what extent will employers be involved in the decisionmaking process in terms of the provisions of health care for their employee beneficiaries, and perhaps more important, will patients have legal recourse should they have a grievance concerning the care they receive through their health care plan.

The goal we all share in designing and crafting this amendment to the McCain-Kennedy-Edwards legislation is how best we protect patients for their medical care without creating an expansive bureaucracy adding to the cost of providing that health care and generally creating an incentive to drive away employers from providing health care insurance to their employees which, as I said earlier, they do so on a voluntary basis. We should be commending employers for providing these benefits, not penalizing them.

We should also take great care to write a provision under which employees remain insured through their employers, while also protecting the employees' rights under their health insurance plans. What we do not want to do is create unintended consequences for employers by leaving legal questions open that can leave employers exposed to liability over matters in which they have no control and over matters in which they have not participated and having the resulting decision.

That is all the more significant when we realize there are more than 43 million Americans who remain without any insurance, and of those who have insurance, employers voluntarily provide health coverage to more than 172 million Americans. Obviously, what we do today is significant, and it will matter.

We cannot afford to have employers suddenly opting out of providing insurance to their employees because we do not want to create the unintended consequence that adds to the rolls of the uninsured in America. I think that is something on which we all can agree, and that is a very real risk. In fact, there was a recent poll taken of businesses in America, and it said that 57 percent of small businesses said they would drop coverage rather than risk a lawsuit.

As one businessman in my State wrote to me recently:

> We're not an HMO or an insurance company. We are an employer. We cannot afford the time, expense, and aggravation of litigation. And, please, make no mistake, that is what this is about.

So we approach the issue of reconciling the differences between the two approaches by addressing the question: What language will deliver us to that mutual goal? We assess what was really the best qualities of the McCain-Edwards-Kennedy legislation, as well as the Breaux-Frist-Jeffords issues.

Ultimately, the solution we came to was a melding of the two approaches. The result was to provide employers with varying levels of liability protection depending on their involvement in the decisionmaking process but regardless, patients will have the legal recourse they deserve, no matter what.

There are many other issues that need to be resolved in this legislation. I realize this represents one facet, the liability question, that has been raised by others with respect to this legislation, and this is not intended to address all of those questions, but clearly it does address a most important issue when it comes to subjecting employers to litigation and liability.

Let me take a moment to explain the differences between the McCain-Edwards-Kennedy legislation and the Breaux-Frist-Jeffords approach and the approach we are taking in the amendment we have offered to S. 1052 and how our amendment affects the underlying legislation and addresses the concerns that have been raised about the net legal impact on employers.

Essentially, there are several categories we are attempting to address today when it comes to employer-sponsored health care insurance.

First, there are employers that contract with an insurance company that, in turn, pays beneficiary claims and administers the plans and the benefits.

Second, there are employers that fund a plan but leave the actual administration of the plan to an outside entity, generally an insurance company.

Third, there are those who both self-insure and self-administer, in essence creating their own insurance company within their existing business.

The McCain-Edwards-Kennedy legislation as written allows a suit against any employer if it directly participates in a decision that harms or results in the death of a patient. Direct participation is defined as the actual making of a medical decision or the actual exercise of control in making such a decision or in the conduct constituting the failure.

The bill then goes on to offer specific circumstances that do not constitute direct participation, including any participation by the employer or other plan sponsor in the selection of the group health plan or health insurance coverage involved or the third party administrator or other agent, or any engagement by the employer or other plan sponsor in any cost-benefit analysis undertaken with the selection of or continued maintenance of the plan or coverage involved.

While the bill language does not provide an exhaustive list of exceptions, it does allow an employer to offer into evidence in their defense that they did not directly participate in decisions affecting the beneficiaries of the health care plan.

That suggests while employer protections would be provided under the legislation, an employer would still have to go to court to make its defense. As with any such legal language, direct participation obviously can be open to legal interpretation, and that precisely is the circumstance which we are seeking to avoid and prevent.

Under the Breaux-Frist-Jeffords legislation that was introduced, the language provides for a designated decisionmaker, or DDM, which in most cases would be the insurance company an employer contracted with to be the party that is liable for medical decisions and, therefore, the party could be subject to liability. In other words, the employer would designate the DDM as the responsible party to shield itself from that liability. If an employer chose not to designate a DDM, they would have no protection from that liability.

An argument that has been made against the Breaux-Frist-Jeffords language is if the DDM is a person designated within a company that self-insures, for example, they could under the employment law attempt to escape liability by claiming that ultimate decision came from the employer; that they, as a DDM, did not make a final decision on a particular beneficiary's case. In an effort to improve the Breaux-Frist-language, we designate that when a contract is signed with the employer, the DDM cannot mount any such defense, that somehow they defer the liability, defer the suggestions that the employer somehow participated in making the decision.

In an effort to improve the employer liability provisions, we encompassed key provisions of both models in the legislation while addressing their inherent weaknesses so we can attain our shared goals.

First, our amendment allows employers that turn their health care coverage to outside insurance companies, that their insurance company will automatically be their designated decisionmaker unless they specifically choose not to have a DDM. This is built directly on the Breaux-Frist-Jeffords model in which the decisionmaking authority shifts to the DDM, which will in most cases be the insurance company. Under this approach, an employer would not have to take the extra steps to secure a designated decisionmaker and would not be required to go to court to file papers or to make defenses against any actions they may have taken. In other words, they would not have to do anything different than

what they are doing today with a contract with an insurance company.

When they sign up with an insurance carrier that will provide benefits to their employees and administer the benefits, they are then signing up with, essentially, a designated decisionmaker, and they are signing up as well for a safe harbor from liability in both medical as well as contractual decisions.

Where we depart from the existing Breaux-Frist language is we clarify since the DDM, which is also the insurance company, has assumed full responsibility at the time the employer and the insurance company signed a contract, the designated decisionmaker would be prevented from turning around and assigning the employer for some failure that resulted in a lawsuit from a beneficiary. In other words, the dedicated decisionmaker can't transfer liability to the employer because of something the employer does or failed to do.

The legislation we have introduced today to modify the McCain-Edwards-Kennedy legislation delineates specifically that the dedicated decisionmaker is responsible for a contractual arrangement as well as exclusive authority for any medically reviewable decisions.

For employers that choose not to have a dedicated decisionmaker, for whatever reason, and for those employers that prefer to continue to be self-insured but contract out the administration of their health care plan, we leave in place the general McCain-Edwards model in the underlying bill that protects employers insofar as they do not directly participate in the medical decisionmaking process.

Again, as I outlined earlier, direct participation is defined as the actual making of a medical decision, the actual exercise of control in making such a decision or in the conduct constituting the failure. These are two of the changes we have made in the amendment we are presenting today from the underlying McCain-Edwards legislation.

In our amendment, we eliminate one element of the bill that would have potentially led to the filing of lawsuits on a variety of grounds unrelated to specific medical decisions impacting individual beneficiaries. The language is, in layman's terms, broad and nonspecific and potentially exposes a defendant to a wide array of nonlegal actions. If additional grounds for lawsuit should be added to the legislation, we should delineate and specify them and not have broad language that essentially leads to a legal potpourri.

Striking this language does not affect the ability of the patient to seek remedy in court for medical decisions made in their particular circumstance. But it does prevent a whole new arena of lawsuits from being created that would heighten an employers' exposure to liability.

In addition, our amendment also modifies the underlying legislation to ensure that self-insured, self-administered plans, employers, and union health care plans will not be subject to lawsuits under Federal law simply because of contractual disputes. This change is critically important when considering that self-insured, self-administered plans do not have the ability to assign liability to a dedicated decisionmaker. As a result, they may opt to simply stop offering insurance for employees altogether rather than risk a substantial judgment on a contractual matter. That is a result, again, we simply cannot afford if we are going to ensure that people have the kind of health insurance plans in America in which they will continue to be insured, and that employers are the ones providing predominantly the health insurance in America today.

To describe our amendment in another way, we essentially are saying as an employer that is not self-insured, you can hand over all your decisionmaking and therefore your liability to a dedicated decisionmaker which will, in all likelihood, be your insurance company when you sign your contract with your insurance company. There is nothing more you need to do to protect your business from liability for the decisions that are made.

For the self-insured and for those who do not self-insure as an employer, you would still have the protections afforded under the underlying legislation if you don't directly participate in those decisions. In other words, employers who contract out their health insurance have a clear choice under our amendment, although once again I stress that under this amendment patients will still have the legal recourse regarding questions over appropriate medical care and medical decisions related to the beneficiary's plan, no matter which option the employer chooses.

The bottom line is we seek to protect employers from liability in cases where they are not making the medical decisions that harm patients or result in death while still protecting parents rights, which after all is the goal of this legislation.

Finally, let me assure my colleagues, under this amendment, dedicated decisionmakers would have to demonstrate they are financially capable of fulfilling their responsibilities as the party liable in causes of action. They could not be shell entities or sham individuals or organizations without the ability to actually pay the event of lawsuits.

The criteria the Secretary of Health and Human Services will require relating to the financial obligations of such an entity for liability should also include an insurance policy or other arrangements secured and maintained by the dedicated decisionmaker to effectively insure the DDM against losses arising from professional liability claims, including those arising from service as a designated decisionmaker. A DDM would have to show evidence of minimum capital and surplus levels that are maintained by an entity to cover any losses as a result of liability arising from its service as a designated decisionmaker. It would have to show that they themselves have coverage adequate to cover potential losses resulting from liability claims or evidence of minimum capital and surplus levels to cover any losses.

Once again, I think we have designed an amendment that represents a workable approach, that addresses some of the more serious and significant concerns that had arisen in the various pieces of legislation that had been introduced here in the Senate and with the underlying legislation we are seeking to amend today.

We try to meld the best of both approaches, to balance the concerns of businesses that do seek to voluntarily provide this most important, critical benefit to their employees. That is an incentive we want to maintain and reinforce in every possible way. But we also understand there are going to be those circumstances in which the employee has received inappropriate care that has resulted in significant harm, injury, or even death, and that they should have the opportunity to seek legal redress for that inappropriate care or denial of care. That is the kind of consideration we want to ensure in this legislation, without creating the unintended consequences or the disincentive for employers to say we just simply cannot afford to provide this health insurance for our employees anymore because we are going to be subject to litigation, to endless losses, and we do not want to put ourselves in the position of that kind of exposure.

I think this approach has been examined on both sides of the political aisle. More important, I think it has been embraced by this bipartisan group in the Senate, my colleague Senator DEWINE, who has worked so hard, Senator LINCOLN whom I see on the floor, and Senator NELSON. They have worked very diligently on behalf of this amendment to assure that we address all facets, all potential implications and ramifications associated with this approach, to hopefully address it in a way that will ultimately yield the best effect for both the employer as well as the employees.

I yield the floor. I will be glad to yield time to my colleague.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. DEWINE. Madam President, let me thank my colleagues, Senator SNOWE and Senator LINCOLN, whom I see on the floor, and Senator NELSON, who have worked long and hard on this amendment.

The issue in front of us today is how do we help shield businessmen and businesswomen from liability at the same time providing access to the courts for people to sue HMOs. Everyone I think agrees, one of the things we worry about as we deal with this legislation is that we will do something that would cause businesses in this

country to decide not to insure employees. That would be a very bad unintended consequence, so we have to be very careful as we write this legislation.

The amendment in front of us today is really a compromise. It is a compromise based on the Frist-McCain bills. It is a compromise on the issue of employer liability, how we best protect the employers while at the same time ensuring people their right in court. I think we have really blended these bills. I think we have the best of both worlds. The situation and the language are clarified and made simpler.

We started this debate with some basic principles on which everyone agreed. In both bills we agreed we wanted to try to protect businesses but at the same time we wanted to allow suits in limited circumstances against HMOs. The President agreed to that principle, and the two underlying bills do as well. This amendment, I believe, achieves that. This amendment effectively takes out 94 percent of businesses and provides them great protection. When you compare our amendment versus the underlying bill, it helps and improves the situation for the other 6 percent. We will talk about that in a moment.

My colleague from Maine has talked about this concept of the designated decisionmaker. What do we mean by that? What we mean is let's just make it simple and let's make it plain; let's have the employer say who is going to make those decisions and therefore who will be sued. In essence, what we are saying is once that decision is made, that employer is no longer going to be subject to suits; the designated decisionmaker will be.

How will this work in the real world? Let's say we have a small hardware store in Greene County, OH. Let's say they employ 12 people, and let's say what they do is they provide some health insurance and they do that by going out in the market, finding the best deal they can, and buying this group coverage for their 12 employees. Under this amendment, once they contracted with that insurance carrier, they would have automatically made that designated decisionmaker decision. They would have designated that automatically, that group as being the designated decisionmaker. They would have to do nothing. They cannot make a mistake. It takes no affirmative action on their part. That is going to improve the language we have in front of us.

The other way of doing it, the way the underlying bill did it, was to talk about direct participation. Frankly, I think the language in the bill was pretty good. But I think it needs to be improved. By having the designated decisionmaker, it is a lot more clear. What will happen as a practical matter is this. As we all know, anybody can sue anybody. We cannot prevent suits, but we certainly can discourage them, and we certainly can provide when suits are filed against a business, the business has the ability to get out of that lawsuit very quickly. So by using the concept of the designated decisionmaker, as a practical matter, if a suit were brought against a businessperson, if a lawyer were foolish enough to file that suit, the business would simply have to go into court and file a copy of that designated decisionmaker decision and would be dismissed from the case. As a practical matter, this language significantly improves the underlying bill and will make a big difference.

Our amendment does build on the two bills in front of us, the two bills we have been talking about and have been considering, the Frist-Breaux bill and the underlying bill we have in front of us today, the McCain-Kennedy bill.

I believe our amendment would protect business owners from needless lawsuits as well as protect patients who rely on employer-sponsored health care plans for their medical needs. I believe this amendment brings together the best of all worlds by providing certainty, much-needed certainty to employers, employees, and, yes, to health care providers. That is something we desperately need in any patient protection bill.

Based on the designated decisionmaker concept in the Frist-Breaux-Jeffords bill, our amendment would automatically, as I have indicated, remove liability from small business owners and shift it to health care providers or other designated entities. In addition, our amendment stipulates this designated decisionmaker must follow strict actuarial guidelines and be capable of assuming financial responsibility for the liability coverage. This means the designated decisionmaker could not be a hollow shell, unable to come up with the money, the assets, to defend against potential lawsuits and financial damages and be able to satisfy those losses. Our language ensures that the designated decisionmaker cannot be a straw man, cannot be a sham that has no ability to pay a patient in the event a lawsuit is filed and that damages are in fact awarded.

In creating the designated decisionmaker process, it makes it easier for employers that provide health insurance coverage to be protected.

We think that is a major step forward for businesses, and especially for patients.

I say that because the fear of being sued often becomes so great that employers simply stop offering health care coverage. We don't want that to happen under this bill. We simply can't let that happen. The reality is in this country that already there are more than 42 million Americans, including 10 million children, who have no health care coverage. The last thing we want to do is add to this number.

Our amendment greatly diminishes the likelihood that employers will stop offering health care coverage. Again, we believe it is the best of both worlds as it allows patients the ability to sue the designated decision maker if they are denied medical benefits to which they are entitled by their health plans. But at the same time it protects employers from unnecessary and costly lawsuits.

Under our amendment, employees would have the comfort of certainty and the comfort of knowing that the designated decisionmaker is ultimately responsible for health care decisions and, therefore, that individual or that entity bears the liability for a lawsuit.

In another effort to keep employees insured, our amendment also adds language to the underlying McCain-Kennedy bill to limit the liability of businesses to self-insure and self-administer their health care plans. The fact is that these employers are assuming additional risk by financing and by administering health care coverage to employees. To that extent, I believe we must take their unique circumstances into consideration. This amendment does that.

Ultimately, our objective is to encourage employers to offer and to continue to offer their employees health care coverage. We don't want to discourage them out of fear that they will be sued.

The reality is that these self-insured and self-administered plans are doing some very good things for their employees. We want them to continue to do these good things. Our amendment will help them keep their employees, their families, and their children insured. That is what the Patients' Bill of Rights should be all about.

Further, our amendment improves the original Frist language by making very clear exactly who is liable. The amendment leaves no room for ambiguity because it would not allow the designated decisionmaker to be broken into sub-decisionmakers. One, and only one, entity would be the sole bearer of liability. We think that is an improvement.

Finally, our language would strike vague and ambiguous language in the underlying McCain-Kennedy bill that is of great concern to employers. This language is a catch-all section of the bill that could open employers to a flood of lawsuits simply because of the imprecise nature of the language.

Let me read the exact language currently in the Kennedy-McCain bill in regard to the cause of action relating to provisions of health benefits. There is the (ii) section. This is what is in the underlying bill:

> Or otherwise fails to exercise ordinary care in the performance of the duty under the terms and conditions of the plan with respect to the participant or beneficiary.

We believe this language is simply too vague. We eliminate it in regard to businesses and their potential liability.

This language that I just quoted creates an explicit cause of action. This means employers could be the subject of lawsuits that none of us currently

has any way to anticipate. The language is broad. It is too broad as currently drafted. Our amendment would completely remove this section.

Finally, I think we must recognize what this amendment does, but also we need to be very clear about what it does not do. Does this amendment solve every problem with this bill? The answer is that it does not. It does what we have said it does. It deals with the heart of the liability problem in regard to businesses, but it does not solve all the problems.

I think it is important for us to have truth-in-labeling with this amendment. It is a good amendment. It is a probusiness amendment. It is an amendment that will encourage business men and women to do what we want them to do, which is good public policy, to insure their employees. It will give them important protections. It will give them more assurances.

That is why we ought to pass this amendment. It is a significant improvement over the underlying bill that is in front of us.

But it does not solve all the problems. It only deals with a portion of the pie. It does not deal with the caps issue. It does not deal with where the lawsuits should be brought and the issue of whether they should be brought exclusively in the Federal court or in the State court. It does not deal with the class action question, about which I am very concerned. And I know my friend from Tennessee has been working on this issue as well. It does not deal with the class action issue. I intend to have an amendment later today or tomorrow in regard to the class action issue.

We want to say what it does. It helps businesses do the right thing. It encourages people to continue to insure their employees. But there are many things it does not do.

I would be more than happy to yield to my colleague.

Mr. GREGG. Madam President, I appreciate the Senator's effort. I haven't had a chance to digest all of it. I understand the intent and the thrust as described by the Senator from Ohio, which I think is appropriate and good.

As I look at the first section, I am wondering. It appears to me that under the definition section it draws union plans in, and they are being given a special status which is really higher than a self-employed plan is given. I am wondering why union plans are suddenly being raised to a special status under the amendment.

Mr. DEWINE. I would be more than happy to answer the question.

In the original language that we have been negotiating for the last few days, we could not figure out any way to really help the roughly 6 percent of businesses that self-insure and self-administer.

My colleague Senator LINCOLN has brought to our attention and businesses have brought to our attention the fact that this amendment as originally written really did not help those 6 percent. Why? Why originally didn't it help? The basic problem is they do make medical decisions. They are really effectively operating as their own HMO.

We thought about how to protect them and give them some help while at the same time preserving their employees' rights to sue just as everybody else has. We came up with a compromise. My colleague Senator LINCOLN may want to get involved in this and explain it a little bit. But basically it says for those self-insured, self-administered plans, we carve out a special exemption for them because of the special status. We say they are excluded and exempted from lawsuits brought in the Federal court on the nonmedical decisions based on the contract decisions. That is a break they are getting. We think it can be justified by what they do because we want to encourage them to continue to do what they do.

Why is the other group that you have mentioned included? They are included because they operate basically the same way the self-insured, self-administered businesses do. They basically take the risk. They basically make the medical decisions.

I appreciate the question, but I would disagree with my colleague the way he has categorized it. This is no special break for unions. This is treating people who operate the same way the same way in the language. I cannot come up with any way to justify carving them out and not giving them the exception because they are operating under the same principles that they are basically self-insured and are basically making the medical decisions, and doing it the same way.

So when you compare apples to apples, you ought to treat them the same. That is why we did it. We think it is justified. We think it makes sense. The option, candidly, would be not to give the 6 percent of businesses this break, not to give them the encouragement to try to get them to continue to do what they are doing. But we came to the conclusion that we should try to help them. We are not helping them immensely, but we are helping them.

Mr. GREGG. If the concept here is to treat everybody in the basket the same, then you have not necessarily done it, because union plans do use third-party administrators and therefore can designate, and a single-employer plan would therefore be more identifiable with the union plan. Yet, under your proposal, the single-employer plan basically is still liable. And that is 56 million people, by the way. Fifty-six million people fall into that category.

So you have exempted out the Wal-Marts of the world, maybe, that allow people to go out and get their health care, and then they come back and get their approval. And that exemption makes sense, but that exemption is not consistent with what unions do. So don't come here and represent to this Senate that it is because it is not. You have raised the unions to a brand new level of independent liability protection. So please do not make that representation.

Mr. DEWINE. I will reclaim my time. I thank my colleague for his comments.

The intention of the language is to treat people equally. If a union does in fact make the medical decisions and if they are operating in the same way that the Wal-Marts of the world are, they ought to be treated the same way. If they are not operating the same way, then they should not be treated the same.

Ms. SNOWE. Will the Senator yield?

Mr. DEWINE. Yes.

The PRESIDING OFFICER. The Senator from Maine.

Ms. SNOWE. The Senator from Ohio is exactly correct. We are treating all employers the same. In this instance, in this particular category, it is those employers who do not have a designated decisionmaker. That is the intent of this particular provision: To treat them equally so they are not subjected to liability when it comes to contractual matters, whereas other employers are not who contract with insurance companies and have a designated decisionmaker. That is what the intent is of this legislation. It is to treat them all equally and to draw that bright line.

We could say, let's not address the self-insured and self-administered programs. I do not think that is fair either because, obviously, they have a different kind of program, and we want to encourage that. We commend them for the kind of benefits they are providing their employees. They happen to be large employers, and they want to design their own internal program. But we don't want to subject them to litigation to which other employers are not going to be subjected. So that is the reason for the intent of this particular provision that happens to include union plans that are designed similarly.

Mr. FRIST. Will the Senator yield?

Mr. DEWINE. I am more than happy to yield to the Senator from Tennessee.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. FRIST. This is an important point, and therefore I think the colloquy is important so we can address it.

We have just seen the language for the first time a few minutes ago. The way I understand it, we have about 170 million people out there we are talking about in an employer-sponsored plan. There are about 6 million people who are in what are called self-insured, self-administered plans. Over the last 2 to 3 years, as we have tried to figure out how to treat these 6 million people in a fair way, we have struggled because it is hard. We have produced the designated-decision-maker model—which I am a great believer in; and I believe most people in this body, if they step

back and look at it, are great believers in—but what you have in your bill is you have carved out those 6 million people and addressed the issue directly, but in addition to that, you carve out the unions.

The argument that was made is that the unions are self-insured, self-administered plans like the other 6 million; that these are union plans, and therefore they should be treated the same as self-insured, self-administered plans.

I think the Senator from New Hampshire and I would argue that the unions should not be carved out as well because—while a few may be self-insured and self-administered—the majority of the union plans are not self-insured and self-administered. Therefore, why are you giving this privileged position to the unions that are not self-insured and self-administered like the 6 million whom you targeted initially? That is the question I think the Senator from New Hampshire and I wish to ask you, because we like very much more the designated-decision-maker model.

I guess the question is, Are you contending that the union plans that you carved out are self-insured and self-administered plans?

Mr. DEWINE. If I could reclaim my time to answer the question.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. DEWINE. I can tell you what the intent was. And, as you know, we have been drafting the language, and it has been going on and on. I can only tell you what the intent was.

I am more than happy to take a minute and look at that language again with your comments in mind.

The intent was to treat people who operated one way equally. In regard to unions, the intent was we would cover union plans that were the same as the Wal-Marts of the world which are self-insured and self-administered. That was the intent. It was not the intent to go one inch beyond that or to cover one group or one plan beyond that.

I will bluntly say, if the language in here is not consistent with that intent, we need to go back to the drawing board and look at the language. That was the intent of the four or five of us who were working on this issue. That was the specific intent, and that was the instruction that was given to staff.

If the lawyers did not come back with that language, and I did not catch it when I read it, I apologize, and we will look at that. But it is going to take us a few minutes to get the language out.

My understanding of what my colleague has said is that if a union does in fact operate a plan, and they are in fact self-insured and self-administered, he believes they should be treated the same way; anybody who runs a plan with those two qualifications should be treated the same way. Is my understanding correct?

Mr. FRIST. We have to be very careful.

Mr. DEWINE. If those are the facts.

Mr. FRIST. We have to be very careful whom we carve out. And then whatever definition we use for the carve-out, we need to apply consistency to it.

Mr. DEWINE. I agree.

Mr. FRIST. I believe we should go back and look at the way the bill is written.

Mr. DEWINE. Let me suggest we take a look at that as we continue this debate. We have a little time to debate. Let us look at the language.

I again want to reiterate something, though. And I do not want any of my colleagues who are watching this back in their office or who are in this Chamber to misunderstand this. This is a limited carve-out. This is not a huge carve-out.

Basically, what this carve-out says is, because of the unique situation of the self-insured, self-administered plans, we are going to exempt them from lawsuits, based on contract, in Federal court—they are not going to be exempt from other lawsuits and in State courts, and based on medical decisions. So it is a limited carve-out. I do not want anybody who is watching this debate to think this is some huge carve-out. It is a carve-out on a limited basis. Our intent was to treat people equally who were in that unique circumstance.

I know my colleague from Tennessee has been wrestling with this for a couple years: How do you deal with these folks who have this unique problem?

I say to my colleague from New Hampshire, this may not be perfect, but we think it improves the status quo. That is sort of what we are about today: Trying to improve the status quo.

Mr. GREGG. Will the Senator yield?

Mr. DEWINE. No, I will not yield yet.

We have had criticism of this amendment from people who say it does not solve all the problems. I came to this Chamber and said, no, it does not solve all the problems, but we are trying. And we are trying with this amendment. If we can improve the amendment, and if we can get the language more precise that does it, I will be more than happy to do it.

Yes, I yield to my colleague.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. I think the language, as presently drafted, is in your definitional section of the amendment where you find ''(ii) (II).'' It says:

> a group health plan that is maintained by one or more employers or employee organizations described in [this section].

That essentially encompasses all union plans. Very few union plans do not use a third-party administrator, very few. So I think you want to tighten up that definition to make it clear that you are applying it to the self-insured, self-funded, self-administered plans, and then you would be picking up the same people that you are picking up under the Wal-Mart exception.

Mr. DEWINE. Reclaiming my time, that was our intent. If that is not reflected in the language, we will change the language.

I yield to my colleague from Maine.

Ms. SNOWE. The Senator from Ohio is making exactly the correct point. This particular provision was intended for those insurers, self-insured and self-administered plans, that obviously do not have a designated decisionmaker. I should further emphasize, all employers are treated equally when it comes to the idea that they participate in medical decisions on behalf of their employees. They are all treated the same. This particular area of the legislation is with respect to contractual decisions. We are attempting to craft out for self-administered, self-insured plans, and that includes union health plans that conform to that particular organization, that they would not be subjected to litigation that other employers would not be subjected to because they had designated decisionmakers.

We know self-insured, self-administered plans do not have designated decisionmakers. So we did not want to expose them to that kind of litigation in this particular section that delineates the causes of action. We were trying to treat all of the employers equally.

Mr. DEWINE. Madam President, I reclaim my time.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. DEWINE. Madam President, we have stated our intent. I think we ought to get about our business and come up with the language to do that, some possible language that we could use. It is always dangerous to try to draft language on the fly on the Senate floor.

I will at least throw this out for possible discussion. We could add ''to the extent the Taft-Hartley Plan Act as self-insured, self-administered plans,'' something to that effect of basically qualifying so that you would get down to whatever the number is—I don't know what the number is—that are self-insured and self-administered. We certainly could do that. There is no reason that cannot be done.

Mr. GREGG. Is the Senator suggesting that additional definition? Is the Senator suggesting that definition, that expansion of the definition, that expanded language be placed on the definition section?

Mr. DEWINE. We could do it that way. If the Senator has a suggestion of how better to do it, I would be more than happy to take the suggestion.

Mr. GREGG. That may well resolve the problem.

Mr. BREAUX. Will the Senator yield for a question?

Mr. DEWINE. I yield to my colleague from Louisiana.

Mr. BREAUX. I ask the Senator from Ohio, I think the discussion has been very helpful. Two points are important to have on the record. A self-insured and self-administered plan by this amendment would not relieve themselves of being subject to litigation for

decisions made based on medical necessity under the Patients' Bill of Rights bill we are adopting.

Mr. DEWINE. The Senator is absolutely correct. We believe the language does reflect that, but that is clearly the intent.

Mr. BREAUX. If the Senator would further yield, the point made by the Senator from New Hampshire is absolutely correct in the sense that on page 3 of the Senator's amendment, line 18, when he talked about that group health plan—basically the Taft-Hartley group health plans, as I understand it—you didn't have that limitation of those that would also be self-insured and self-administered. I think if you added that to that definition, you would correct the problem. I think it would be in keeping with what the Senator wants to do and certainly something I could support.

Mr. DEWINE. I appreciate my colleague's comments. I think they are well taken. We will get about the business of dealing with that. The point is very well taken.

I yield the floor.

The PRESIDING OFFICER. Who yields time? The Senator from Tennessee.

Mr. FRIST. Madam President, I yield myself approximately 15 minutes on the opposition time for the time being.

The PRESIDING OFFICER. The Senator from Maine has 7 minutes remaining in her time on the proponent's side.

Mr. FRIST. Madam President, is this 4 hours evenly divided?

The PRESIDING OFFICER. There are four 1-hour segments. The Senator from Tennessee controls 1 hour of the 4-hour time. The Senator from Maine controls 1 hour. She has 7 minutes remaining on her hour. The Senator from New Hampshire controls 1 hour, and the Senator from Massachusetts controls 1 hour.

Mr. FRIST. Madam President, I ask unanimous consent that for the first hour, it be equally divided so we can continue the debate for those in opposition.

Mr. REID. Madam President, I am sorry. What was that request?

Mr. FRIST. For the first hour of the debate, which we are about, I guess, 20 or 30 minutes into, the opposition has not had the opportunity to speak. I was saying for the first hour, in which about 25 minutes has been used, if we can have 30 minutes on either side.

The PRESIDING OFFICER. The debate has already consumed 53 minutes on the proponent's side controlled by the Senator from Maine.

Mr. REID. The Senator from Tennessee has an hour. He can use it any way he wants.

Mr. FRIST. Madam President, I understand I have an hour on my side. I will use time off our side at this juncture. I yield myself such time as necessary.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. FRIST. Madam President, first of all, let me put perspective on this because we have had the amendment introduced, and there are basically three points I want to make.

No. 1, I applaud the Senator from Ohio and the Senator from Maine because they have, for the first time in the debate, addressed this issue of suing employers—this issue of who is responsible, who gets sued, if there is harm or injury or cause of action. As one can tell from their earlier discussion, there has been a lot of debate in struggling with how best to address who you sue and when you sue them and what entity. There is not very much certainty out there. Do you sue the plan? Do you sue the employer? Do you sue the agent of the plan? Do you sue the physician or the hospital when there has been harm or injury?

In the McCain-Edwards-Kennedy bill, there are exclusions for the physician and the hospital. However, the argument and the debate over the last 4 or 5 days has made it clear that you can sue the employers if they directly participate. And what has now been brought to the floor in a very positive way, I believe, is this concept of giving certainty to all that through a model that is called the designated-decision-maker.

Really all that means is that since somebody is going to be sued—and the way it is designed now, you don't know who it is; that doesn't give anybody certainty—the easiest thing to do is for an employer to walk away. It might be me that is sued. It might be the entity that is administering my plan. It might be an agent of that plan. That is so confusing and puts so much risk out there, and you never know whether you are at risk or not, or somebody else, or who the lawyers will be going after. The designated-decision-maker says: We are going to all get in a room and say there is one entity responsible. If there is a lawsuit, you are going to go after that entity. That entity has to bear the risk, and also whatever value there is for that risk will have to be either purchased or sold. That gives certainty to the overall liability issue.

The second point—I will come back to this—that is very positive in the underlying amendment is this broad cause of action which is being struck from the underlying bill. That is where the underlying bill, when you go to the Federal level in the underlying bill, there is a cause of action called ''duty under the plan.'' Unfortunately, if you leave that cause of action in there, it sweeps in all sorts of things, whether it is the HIPAA regulations or the COBRA regulations, and all of a sudden for those sort of indications, you don't have just compensation, but you are exposed to these unlimited lawsuits out there. So it is very positive, in the amendment that has been put on the floor by the Senators from Maine and Ohio, to take that cause of action out of the underlying bill.

The third point is that the Senator from Ohio made the point that this is not the answer to liability. Liability involves exhaustion of appeals. And we have an amendment pending on the floor addressing whether there should be caps; and that entire debate, once you get to courts, whether it is noneconomic damages or punitive damages, involves whether you to go Federal court or State court and then this whole idea of who do you sue. Can the employer be sued? And that last point is what the designated decisionmaker selectively looks at, that sliver of the pie of liability.

So far in the debate, over the last 4 or 5 days, we have not addressed Federal versus State jurisdiction, whether or not there are caps, full and completion exhaustion, or should there be class action suits. The Senator from Ohio made that point. It is critically important to address. If you read the press on this, this decision-maker model will take care of the liability. But it does not answer the questions on the part of myself and many others.

The history of the designated-decision-maker model is interesting as well. It is in the Frist-Breaux-Jeffords bill. The amendment on the floor is very similar to what is in the Frist-Breaux-Jeffords bill in that you give certainty; you have to name an entity to be the designated-decision-maker. That is who you sue. The Frist-Breaux-Jeffords bill based that on what already passed the Senate about a year and a half ago. A designated-decision-maker amendment passed this body. That amendment came from the conference last year, where you had Democrats and Republicans sitting around a table addressing how to come up with a system that best addresses this problem of having employers being sued out here when you really want to go after HMOs. How do you delink employers versus HMOs?

Basically, you make one entity responsible. It could be the employer, if they meet certain financial criteria; it could be the HMO; or the HMO might contract with another entity. But somebody has the risk. They have to have the financial wherewithal that equals that risk or the potential of that risk. So I love the designated-decision-maker model. It is clearly needed and necessary.

Let me take a minute. We keep drawing references to the Frist-Breaux-Jeffords bill and the way that worked, because whether or not I can actually end up supporting the amendment of the Senators from Maine and Ohio really depends on how close in my own mind we get to the underlying model that is in the Frist-Breaux-Jeffords bill. I believe that gives the most certainty—certainty to the employer and also certainty to the employee, at both levels.

The way that process works is there is an internal and external appeals process. Under the Frist-Breaux-Jeffords bill, you can't opt out of that and go directly to the court as you can in the McCain-Edwards-Kennedy bill. We are trying to fix that through another bill.

In the Frist bill, once you go through the internal and external appeals and you go to court, you are going to end up going to Federal court. If there is a lawsuit in advance, prospectively—not after the fact—a designated-decision-maker has been identified. If there is a lawsuit, there is no question of whether you sue the employer or the HMO or the agent of the plan or the hospital or the doctor. Indeed, you sue one person. There is no choice. It is the designated-decision-maker. That is decided in advance.

The Snowe-DeWine amendment takes that concept. Again, I think it is the right way. I think most people would agree that is the most appropriate way to address this issue of employer liability. But what they have done is given a choice, from direct participation, of the decision-maker model. To me—and I will have to be honest—that leads to some sort of uncertainty because instead of having real certainty in the employer's mind and employee's mind, the beneficiary of the plan, that there is one person, and you know in advance a year before, 6 months before, that they have the responsibility, and somebody has paid for it. Instead of having that certainty, you introduce more choice. Again, are they directly participating? Are they in the decision-maker model? The debate we just heard—are they a self-insured, self-administered plan which is carved out of the Federal cause of action, or are they a union plan? We just heard that debate. Some are self-insured. Some are not. Why carve unions out there? We will look at that particular language. All of that uncertainty is avoided with the designated-decision-maker model.

Now, that second point that I have already mentioned, which is very positive in this bill—probably more positive, I believe, in the amendment introduced by the Senators from Maine and Ohio, is the part of their amendment which deletes the provision in the underlying McCain-Edwards-Kennedy bill that would allow lawsuits against employers and insurers for unspecified failures—and I quote from the bill—''in the performance of the duty under the terms and conditions of the plan.''

That is the language which is going to be deleted. That is important because if you don't take that out of the underlying bill, employers will still be highly vulnerable to lawsuits based on alleged failures in the whole realm of administrative duties. That could be under HIPAA, the Health Insurance Portability and Accountability Act, which we passed in this body several years ago, and COBRA, whereby employers are not allowed to delegate administrative duties, under those laws, to anyone else, by law. You can't. So the liability for those administrative duties, because you can't delegate, would fall on the employer, thus allowing the employer to be sued. So that is very positive, I think. It was addressed directly in the amendment, and I commend them for that.

Third is that we need to understand throughout this debate, as we hopefully can refine this amendment and pass it if we can resolve some of the specific issues in the language. We need to be crystal clear again that addressing the designated-decision-maker addresses the employer aspect of liability but does not address the many other factors of liability, which I think we have a responsibility to address on this floor, since this bill never went through committee and, in truth, we are marking up and writing this bill for the first time on the floor. We need to talk about Federal versus State courts, class action suits, whether or not there should be caps in a noneconomic damage or should there be punitive damages. All of those other issues have not yet been addressed. Now I am quite pleased we are addressing the designated-decision-maker aspect of employers being sued.

Several quick examples. There need to be clear and effective limits, I believe, on class action lawsuits. There need to be firm requirements that we fully exhaust internal and external reviews before initiating any lawsuits. There are a lot of broad exceptions. We talked about some of them as the Thompson amendment was on the floor; we have addressed it. We have to have complete exhaustion as we go through.

Second, if an independent external medical reviewer, who is a doctor, which is in the Frist-Breaux-Jeffords plan, as well as in the McCain-Edwards-Kennedy plan, upholds the plan's denial, then the plan should not be subject to liability. We need to discuss that on the floor. In the underlying McCain-Edwards-Kennedy bill, a patient can still sue, even though that independent medical reviewer, a physician with age-appropriate expertise, has decided that the plan made the right decision in internal and external appeals and the physician says everything was right going through. I believe the Frist-Breaux-Jeffords bill says, no, you can sue for care, injunctive relief, but not for extraordinary rewards. That has to be addressed.

Also, the underlying McCain-Edwards-Kennedy bill would allow the independent reviewer to ''modify''—I believe that is the word used—the plan's denial. And this is just as a physician. What it means is that in a paper review you never see the patient. You read records and hope they are complete, and the reviewer is going to have the opportunity to maybe do thousands of these, maybe hundreds, maybe 10. I don't know. I was with a doctor a few minutes ago who has done thousands of these reviews.

The point is that you never see the patient. You never get the subtleties of clinical diagnosis, which all of us know is science, but there is also art to it. You are asking somebody to look at this paper and review it and say, yes, it was right or, no, it was wrong.

With the information written on that paper, you are allowed to come in and modify the treatment of that patient. I can say as a physician the fact that based on that paper review, a reviewer could require that the plan cover treatment that neither the treating physician nor the plan ever contemplated or ever recommended, this reviewer who maybe over the telephone is reading it, is going to be able to modify it bothers me.

It bothers me because it becomes binding, and we all know it becomes binding. When it becomes binding and you have not had that direct experiential observation, to me it is not right. It needs to be corrected.

I will give another example: The employer in the plan would be subject to simultaneous litigation in Federal and State court. Again, speaking to the underlying bill, we have to address that because we all know when we have lawsuits which result in—take a $120 million damage award such as there was 2 years ago. A $120 million award is a large award. Some will say it is too much; some will say it is too little. But a $120 million damage award results in total premiums being paid for about 55,000 enrollees on average.

I do not want to correlate the two, but $120 million is a lot of money, and, at least in my mind, I come back to the uninsured and the number of enrollees who could go out and buy insurance.

We need to be careful about encouraging shopping between the Federal courts and State courts, and once you get to the State courts, from State to State. Maybe tomorrow, Saturday, Sunday, or Monday we will come back to that and talk about it. Clearly, if you are an attorney, for a single event, you have multiple causes of action, you can question that, but in addition to that, you have multiple venues: the Federal court, the State court, or from State to State to State. That is our interpretation. That is our attorneys' interpretation. It has to be fixed.

In closing, I support the designated-decision-maker model. The Senators from Maine and Ohio are to be congratulated for the first time in this Chamber addressing in a sophisticated, appropriate way how to clarify the uncertainty about suing employers versus suing HMOs.

I support the model. It is in the underlying Frist-Breaux-Jeffords bill. We are looking at the language, as we speak, on the issue of unions and why they are specifically carved out. That needs to be addressed. We hope to have factual information. We will read the language, and I look forward to working aggressively with the authors of this amendment so we can all rally around it.

Mr. DEWINE. Will the Senator yield?

Mr. FRIST. Yes.

Mr. DEWINE. If I can respond to the Senator's comments about why we crafted the bill, it was to give the employer a choice as to whether or not they would go under the designated decisionmaker or under the language of the other bill, which is direct participation.

Frankly, I do not think this is a huge deal. The reality is that the vast majority of businesses will go under designated decisionmaker, and, in fact, we provide in the bill that it is automatic. That will just happen unless they make a conscious decision to say: We do not want to do the designated decisionmaker; we want to go under the direct participation language.

We are in an unknown area, and I do not think anyone knows how this is going to play out entirely in the real world and what decisions they are going to make. Some people come up with some scenarios under which they would not want to designate someone as a designated decisionmaker. The vast majority are. We wanted to provide this as a fallback position, more options.

I do not think it is going to make it more ambiguous or less definite because we provide automatically it is going to be designated decisionmaker unless they make an action and say: No, we do not want designated decisionmaker; we want to go with our model because for some reason it works that way. We can look at the language and talk about it.

In explanation to our colleague from Tennessee, that is what our thinking was. We do not know where the world is going with this new language, and we wanted to give as many options to businesses as we could. That is why we did it.

Mr. FRIST. Mr. President, I claim my time.

The PRESIDING OFFICER. The Senator from Tennessee.

Mr. FRIST. I guess this decision of certainty—I usually like choice coming through, and it appeals to me. I am a 50-person convenience store operator and have three or four convenience stores in the area, and I have people barely scraping by, working minimum wage, but I recognize giving people some insurance goes a long way. Some people say it does not matter; you still have your care. If you have insurance, you end up getting better care in the United States of America, it gets you in the door. We talk about the 43 million uninsured, and we all care. It bothers me in a direct way.

I am that operator and I know I am going to have to find a designated-decision-maker. That is going to cost money because it is liability; it is increased liability. I do not know, but if I have a choice, I am going to say I am barely scraping by and it is just easier for me not to play at all. Dealing with designated-decision-maker, you have that choice. If that is the case, I fall back to the direct participation language, and the direct participation language has all of the other problems. The pressure of the system is going to be such because direct participation does not cost you much, but if you get sued for $120 million or in 1993 for $89 million or in the year 2000 for $80 million. That is real; just one case.

If I am sitting in my convenience stores and I say designated, this is the new model created by the U.S. Congress; I am not going to participate in it; it is too expensive. Thereby I go back to direct participation, and we are where we are now.

It is easier to walk away and not give even those 30 employees insurance out of fear, out of risk. That is why with the direct participation model, as long as everybody plays and everybody is certain it has prospective certainty for the employer and employee, people are not going to drop their insurance.

I will be happy to yield the floor.

Mr. DEWINE. To respond, as envisioned by the Senator's original bill—and the Senator from Tennessee is the one who came up with the language of the designated decisionmaker and I applaud him for it because no one has come up with one better. This is the model. This language is pretty much the Frist bill. But in the Senator's example, the designated decisionmaker is going to automatically—you have this company that has three or three convenience stores; they have who knows how many employees; they buy insurance. Their designated decisionmaker is automatically going to be the group handling the insurance. They will not have to make a conscious decision at all. It will just happen. That is the glory of the way it is written and of the Senator's original language, that it is automatic; it is going to happen. They are not going to have to look for a designated decisionmaker.

Under the language of the Senator from Tennessee, it is going to take care of itself. That is the strength of it.

Mr. FRIST. May I use 1 minute and then I will yield on that issue. I want to respond to that.

Mr. KENNEDY. May I ask a question? We have two other cosponsors of the amendment. They have yet to have a word.

Mr. FRIST. How much time has been used by this side?

The PRESIDING OFFICER. The Senator from Tennessee has consumed about 22 minutes.

Mr. FRIST. How much has the other side used since we have been on the amendment?

The PRESIDING OFFICER. The other side has used 53 minutes.

Mr. FRIST. They have used 53 minutes, and we have used 22 minutes.

Mr. KENNEDY. How much have we used?

The PRESIDING OFFICER. The Senator from Massachusetts has used none.

Mr. FRIST. I was speaking in opposition to the amendment.

Mr. KENNEDY. I think the presenters ought to be entitled to whatever time they have remaining. I am a strong believer in that. I would like to invite our cosponsors to have a word.

The PRESIDING OFFICER. The Senator from Tennessee still has the floor.

Mr. FRIST. Thank you, Mr. President. A matter of clarification, in speaking in opposition to the amendment, yielded by Senator GREGG, we have used how much time?

The PRESIDING OFFICER. Twenty-three minutes.

Mr. FRIST. Twenty-three minutes since we have been on the amendment. Clarification: The proponents have used how much?

The PRESIDING OFFICER. Fifty-three minutes.

Mr. FRIST. I will be happy to yield the floor in a moment. Clarification on the designated-decision-maker model: We would not necessarily assume the insurance company is the designated-decision-maker. You would have to designate that, and that is part of our Frist-Breaux legislation, just to clarify that.

Ms. SNOWE. Will the Senator yield?

The PRESIDING OFFICER. Who yields time?

Ms. SNOWE. Will the Senator yield on that point?

Mr. FRIST. I will be happy to.

Ms. SNOWE. It is important to emphasize in this amendment as we have drafted it includes a provision that starts out with automatic designation: That a health insurance issuer shall be deemed to be a designated decision-maker for purposes of subparagraph (A) with respect to participants and beneficiaries of an employer or plan sponsor.

That is important to emphasize, and it automatically occurs so we remove the ambiguity, extra steps, cost, and so on, with respect to that particular requirement.

Mr. KENNEDY. I yield such time as he desires to the Senator from Nebraska and then the Senator from Arkansas, two lead sponsors.

The PRESIDING OFFICER. The Senator from Nebraska.

Mr. NELSON of Nebraska. Mr. President, I thank the Senator from Massachusetts for the opportunity to speak to this amendment. There has been a lot of discussion recently and I think most people's heads are swimming about what a DDM is and what the purpose of this amendment truly is.

The purpose of this amendment is to make sure, whether you are a plan sponsor or an employer, if you are self-insured and self-administered, that you are treated the same. You have to treat one and all the same. That is what this is about. I believe there is some language being worked on that probably will be offered shortly to make it clear that is exactly what is intended by this amendment. It does not specifically carve out one group or another. It carves out all groups where there are plan sponsors or employers who are self-insured and self-administered. All other employers are in a position to have a DDM, designated decision-makers, or they have an insurer which is a designated decisionmaker.

The whole purpose of this legislation is to be able to provide additional rights and opportunities for insurance. This does it. What it also does is make sure that employers are not entrapped in unnecessary litigation and that if they don't make decisions about health

care and make decisions about claims, they are not involved in litigation.

Specifically, this amendment narrows it down to not being brought into Federal causes of action. It does not absolve employers or plan sponsors from any kind of litigation that may come through State courts.

While it may be difficult to follow the roadmap, there is one thing that needs to be clarified and that is, it does not treat any one group in any special way. It treats all plan sponsors and all employers who self-insure and self-administer, the same way. If they choose to get a third party administrator, which becomes a designated decisionmaker, they will be absolved from liability from litigation unless they somehow participated in the claim-making process, which they would not do if they had a designated decisionmaker. This is intended to make sure we balance the interests of the right of the individuals, the right of the patients to sue, with the opportunity for employers not to be entangled in litigation where they should not be entangled. It also means that in balancing these interests, there will be fewer cases of uninsureds, and there will be fewer employers deciding to get out of the business of providing health insurance benefits to employees.

We have heard from employer after employer about their concern—as a voluntary provider of these benefits, now suddenly they can be sued. This makes it clear they will not be sued and it also makes it clear that those who are plan sponsors will not also be sued unless they participate in making decisions about health care claims. That is what this is all about.

I hope this clarifies it for some of my colleagues on the other side of the aisle who have raised questions. It is important to raise questions and certainly ask the question whether there is any special treatment. But if you look at the language and you look at what is being done, there is not any special treatment for one group over another. The category is the same. If you self-insure and self-administer you will be open to some exposure. However, we will make certain that exposure is limited when it comes to Federal actions. That is what this is about.

I yield to my colleague from Arkansas and say before departing, thank you to my colleagues and cosponsors from Maine and Ohio. I believe this is the right way to proceed to improve this bill.

The PRESIDING OFFICER. The Senator from Arkansas.

Mrs. LINCOLN. I am the last of four children and I am the last in this line of four, and I am delighted to have waited patiently to rise today and speak in support of an amendment I am offering with Senator SNOWE, along with Senator DEWINE and Senator NELSON, to protect employers from liability.

The good Senator from Tennessee, Dr. FRIST, would certainly join and agree, as we have taken a good bit of his designated decisionmaker language, that our ultimate goal is to protect the rights of patients while ensuring that employers who provide health care are not subject to frivolous lawsuits.

The objective is to those individuals, the good guys in this bunch, the employers reaching out and providing the kind of health care that Americans need; that we can work within the confines of this bill and within this amendment to ensure they can continue doing that. That is exactly what we have attempted to do. I think we have worked long and hard. I know my colleagues and I have worked long and hard to develop language to do just that, in working with those employers who want to provide the much needed health insurance that Americans want.

Employers that are offering health insurance are the good guys. We don't want to discourage them from offering health insurance. This amendment provides the assurance they need to those offering health insurance, that if they do not make medical decisions or override medical decisions, they are not liable. Again, I know the good Senator from Tennessee, Dr. FRIST, understands that in terms of making sure those who are not making medical decisions are not going to be held liable.

We have worked hard on the underlying bill, as the Presiding Officer knows, as we have talked in many press conferences on some of the most important issues to the American people. This Patients' Bill of Rights is one of those issues. We have reached out.

The opponents of the Bipartisan Patient Protection Act have argued that the Patients' Bill of Rights will drive up health care costs by subjecting employers to increased liability and frivolous lawsuits, and in turn they argue rising costs will force employers to drop health insurance. Our amendment presents an innovative solution to this potential dilemma. We have been able to provide the protection needed by these individuals who are already out there doing the right thing.

By allowing these employers to design this designated decisionmaker, a term presented from the Breaux-Frist legislation, to oversee medical care decisions, we remove most large and small business owners from the threat of liability. They have that option of choosing a designated decisionmaker. We make it possible for employers to contract with a third party to administer health benefits and protect themselves from unnecessary and crippling lawsuits. This amendment makes it crystal clear that employers will not have to open themselves up to new liability as a result of providing health insurance to their employees.

When we began discussing the Patients' Bill of Rights years ago, we wanted to ensure that patients would be able to choose their own physicians and their medical professionals—not accountants, not bureaucrats, not insurance company executives, but the medical professionals—would make the medical decisions. We never, absolutely never, intended to open employers up to liability. And we certainly don't want to do anything in this bill that would discourage these employers from providing health insurance to their employees.

We are delighted to work out the clarifying language that Members believe is needed to assure everyone is treated fairly.

The amendment I offer today refutes the charge that the Patients' Bill of Rights is a trial lawyers employment act. Today we make it clear that we have absolutely no intention of subjecting employers to new liability or frivolous lawsuits. We want to encourage our employers in this country to provide health care coverage for their workers.

In 1993 when we began the discussion of health care, we made it our objective to get more individuals covered under health insurance provided by their employers. We were able to do that. Unfortunately, we have more uninsured in this country today, and we do not want to exacerbate that problem. We want to give these employers the comfort that they need, to feel confident in keeping that employee insurance available.

This amendment is our pledge of good faith to American employers and business owners that we will protect their needs as well as the needs of their employees.

I applaud the work of my colleagues. I have enjoyed working with them. I appreciate everyone's patience and endurance in this process. We hope to be very inclusive, to bring others in to make sure this language is exactly that: It is giving the protection and the comfort level to the employers of this Nation that are doing an excellent job in providing health care to their employees.

I also ask unanimous consent that Senator BAUCUS be added as a cosponsor to this amendment, and I yield.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Massachusetts.

Mr. KENNEDY. I yield the Senator from Michigan 5 minutes.

Ms. STABENOW. Mr. President, I rise first of all to ask unanimous consent to add my name as a cosponsor to this amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Ms. STABENOW. Mr. President, I thank my colleagues on both sides of the aisle for their hard work and the innovative language that is put together in this amendment. For those of us who are sponsors of the Patients' Bill of Rights, we have said since the beginning this was in no way intended to allow lawsuits to be brought against employers, this was about making sure those who make medical decisions were held accountable for those medical decisions.

As we said so many times on the floor, it is really about closing a loophole in the law as well. We have indicated over and over again, when you have only two groups of people in this country who are not held accountable for their behavior and their decisions, one being foreign diplomats, the other being HMOs, it doesn't make any sense. We know this was a loophole that was created by the outgrowth of HMOs and development of new ways of managing health care, and basically the Patients' Bill of Rights is meant to clarify that and make sure those who are making medical decisions are held accountable for the outcomes of those medical decisions, just as are doctors and nurses and other medical professionals.

What I think is important about this amendment is it very clearly states to each and every employer, large and small, that in fact we will make sure if they are not making medical decisions—and in the vast majority of times an employer is not making a medical decision—the intent of the Patients' Bill of Rights is not to create a liability for the employer. We have employers, many in Michigan—hundreds of thousands of them—who are responsible employers, providing insurance for their employees. We want to encourage and support and salute them for doing that and make sure nothing gets in the way of that continuing.

I again thank my colleagues from both sides of the aisle who have put in a tremendous amount of work on this amendment. There has been a wonderful job done clarifying this. I hope we have now been able to put to rest what was unfortunately a common misperception, something said over and over again to employers of this country, that somehow this opens them up to lawsuit. It never was the intent. This amendment clarifies that and reiterates it.

I hope this will allow us to move forward, to pass this very strong Patient Protection Act that says to each and every family: When you have insurance you can have the confidence, whether it is in the emergency room or the doctor's office or the hospital, that you will have the care available that your family needs.

I will yield the floor.

The PRESIDING OFFICER. Who yields time?

The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I yield myself 3 minutes.

Both the Snowe amendment and the Frist amendment attempt to protect lawyers using the designated decisionmaker language. However, the fact that they use similar names can't mask the dramatic differences between these two amendments. Senator SNOWE's amendment helps employers without hurting patients.

There are two important differences between the designated decisionmaker language in the Snowe amendment and the Frist amendment. Senator SNOWE's amendment ensures that the person an employer designates as responsible and will be liable for all damages caused by any wrongful benefit determinations the patient gets under our bill. This is exactly what employers want and deserve, a clear way under the law to protect themselves.

The Snowe amendment allows employers to name an HMO or health insurer or plan administrator as their designated decisionmaker and not have to worry anymore about being sued. That is what President Bush wants, and that is what we want. If employers give up all control over medical decisions in individual cases such as this, Senator SNOWE's language helps guarantee employers will not be sued, period.

Senator FRIST's designated decisionmaker language is much weaker. Under his proposal, the only entity that can be sued is the designated decisionmaker. While the designated decisionmaker is supposed to have exclusive authority to make benefit determinations, a court or jury remains free to find in fact another person or company influenced the decision that caused the harm. People who are not designated decisionmakers may in fact influence decisions and share liability. But the Frist language leaves victims no way to hold these outsiders accountable. That is because, unlike the amendment of Senator SNOWE, the Frist amendment never deems the designated decisionmaker liable for the acts or omissions of other parties who affect benefit determinations. This is the most critical difference between the two proposals.

The other important difference is that under Senator SNOWE's amendment, only employers can name designated decisionmakers; HMOs cannot. After all, the entire point of having designated decisionmakers is to ensure employers have a clear, easy way to avoid all possibility of being sued, not to protect HMOs.

Of course, the effect of allowing HMOs to have a designated decisionmaker is to enable them to escape liability for part or all of their actions. Under the Frist-Breaux amendment, if a judge or jury finds someone in an HMO harmed a patient and that person working for the HMO was not a designated decisionmaker, the HMO escapes liability.

I think the amendment is sound. I think it has been a matter of discussion and debate. I think those of us who were involved in the development of the initial legislation sought to achieve what this amendment does enormously fairly. It also treats the various Taft-Hartley aspects equally with the other parts, so we have equality for one and equality for the other.

Another important feature of Senator SNOWE's amendment is that it protects employers and Taft-Hartley plans which self-insure and self-administer claims. The Frist alternative contained in S.889 fails to address this issue. The Taft-Hartley plans have a long history of providing quality health care for their members. In their unique structure, employee advocates comprise half of the members of the board. The record shows that this has been an excellent protection even for beneficiaries who have extraordinary health care needs. In structuring this legislation, we wanted to be certain that we didn't impose any inappropriate burdens on these plans.

I commend the Senators. They spent a great deal of time on this amendment. One would think it would be easy in the drafting of it, but I know they have been challenged with it. I commend them for really advancing this whole issue in a very positive, constructive way, a way which really reflects what this President has enunciated and a way which we had hoped to include in our legislation. There was a significant question about it. Legitimate issues were raised. I think this is one of the important contributions in helping move this process. I commend all those on both sides who were very much involved in its development.

The PRESIDING OFFICER. Who yields time?

Mr. KENNEDY. Mr. President, I yield 5 minutes.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. EDWARDS. Mr. President, this amendment is a wonderful example of what can be done when we work together to solve problems. The beneficiaries of the work that has been done by Senators SNOWE, NELSON, DEWINE, and LINCOLN are not the Members of the Senate but the people of this country, the families who need quality health care, and the employers that need to be protected from unnecessary lawsuits and unnecessary litigation.

First, I thank Senator SNOWE for her leadership. She has taken the lead on this issue from the beginning. Her work has been absolutely crucial.

My friend, Mr. DEWINE, the Senator from Ohio, has also lent tremendous leadership and expertise to the work on this effort.

I also thank my colleague seated near me, Senator NELSON from Nebraska, who not only brings great expertise to this issue both as Governor and as insurance commissioner of the State of Nebraska, but he has been dogged in his determination to ensure that the small employers, particularly, and employers generally, of America are protected in this legislation.

This effort could not have been achieved without his leadership and without his dogged involvement in this issue. He has been involved in so many of the issues with respect to this legislation. He and I have worked together. He and I and Senator MCCAIN have worked together. He has been involved in this patients' rights protection act from the very beginning. We thank him for all of his work and important contribution.

Also, the Senator from Arkansas, who has expressed a concern about employers from the very first moment,

and I have talked about this issue. She cares deeply about patients and deeply about doctors making medical decisions, having a very well-trained physician in her own family, that being her husband. She has firsthand experience with that. But in addition to that, she has shown great concern for small employers and, as has Senator NELSON, has made it very clear to Senator MCCAIN and myself and Senator KENNEDY that the only way she could support this legislation is if we did what was necessary to protect employers. She has been absolutely crucial in achieving that goal.

Without the work of Senators LINCOLN, NELSON, SNOWE, and DEWINE, the employers of this country would be in a different place than they are today. I think they will be after this amendment is voted on.

They have achieved two very important purposes:

No. 1, they have insured that there are real and meaningful protections for employers through the designated decisionmaker model which we have already talked about, which essentially means the small employers that we have talked about are 100-percent protected. They cannot have liability under the language of this amendment, which is crucial. It is a goal and a principle that we have all shared from the beginning but, again, couldn't have been done without their work. They have also managed to do it in a creative and innovative way that, while protecting employers, does not leave the patients and the families high and dry, which is exactly what needed to be done.

Honestly, it is a very difficult task, but they have worked doggedly on this issue. All of them managed to reach a bipartisan agreement.

The most important thing from the perspective of the overall legislation is that this is another in a series of obstacles about which we have now been able to reach some consensus.

They have followed sort of one by one by one, starting with the issue of scope, which Senator BREAUX, Senator JEFFORDS, I, and others worked on, reaching a crucial compromise going to the issue of independence of medical panels to make sure that those panels are, in fact, independent.

We have reached a resolution of that issue. On the issue of medical necessity, the Presiding Officer from Delaware, along with my friend, the Senator from Indiana, were crucial in being able to reach a resolution that shows proper respect for the sanctity of the contract and the specific language of the contract but some flexibility, where necessary, for the independent review panel with respect to patients, keeping in mind the interest of patients on the one hand, which I know you care about deeply, and the importance of the contract in keeping costs under control.

Without your work and Senator BAYH's work, that would not have been achieved.

The Senator from Tennessee and I, as we speak, are attempting to finalize an agreement on the exhaustion of appeal. Both of us believe, as do most Members of this body, that it is a sensible thing to have a patient go through the internal and external appeal before any case goes to court. We have tightened up that language; working together on it. We know it is important.

The Senator from Tennessee, Mr. THOMPSON, and I are resolving this issue of the exhaustion of appeal. All of us believe that the appeals process is crucial to getting patients the care they need.

If this bill works the way Senator MCCAIN and Senator KENNEDY and I believe it should, the ultimate goal will be achieved if there were never a lawsuit filed because what would have happened is the appeals process would have worked and the patients would have received the care they needed. That is what this is about.

We want patients to use this appeals process. The Senator from Tennessee and I are finalizing an agreement on exhaustion of administrative remedies.

I also want to thank our colleagues on this specific amendment because that is another crucial obstacle. Scope, independence of the panel, protecting employers, medical necessity, and exhaustion of appeals are crucial issues in this legislation about which we have been able to reach consensus.

As I said earlier, the important result is not what is happening within this Chamber but that the families of this country will have more control over their health care, and we will actually have a more realistic possibility of getting the legislation they so desperately need passed.

I thank all of my colleagues for all of their hard work. Without them, this could not have been achieved.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. Mr. President, let me begin by saying that this amendment is moving in the right direction. I believe, with some of the changes which we have discussed with the Senator from Ohio and the Senator from Maine, that we can make real progress on improving it. Unfortunately, the amendment came late. It is complicated. The issues involved are considerable. But before getting into the specifics of the amendment and how it may or may not play out in a positive way relative to producing a quality bill, let me make the point that this amendment addresses an important but not a broad part of the issue.

This amendment doesn't, for example, address some very real and significant issues in the area of liability. It doesn't address the issues of the 56 million people who are in self-insured plans.

It does not, therefore, solve the overall liability question, which if you were to rate the five issues that I think the Senator from North Carolina has appropriately highlighted, although I am not sure he mentioned liability—he probably wasn't thinking in those terms, but he certainly hit the floor if you put liability on the table—liability is probably the key issue for a lot of people in this Chamber.

Issues such as forum shopping, class action, damages, punitive versus compensatory damages, are major issues that we still have to address. I think we recognize that there is still a fair amount of distance to go in the liability area.

But this amendment takes up the designated decisionmaker language. It takes a portion of the Frist-Jeffords-Breaux bill in this area and tries to basically graft that on to what is the McCain-Kennedy bill—a good and appropriate attempt, although I must admit that with just a quick reading of it I think there is going to be some real confusion on the part of employers between what they can do as a designated decisionmaker versus direct participation. I had hoped that the language would have a firewall in there. But as a practical matter, at least the movement is in the right direction to give some insulation for designated decisionmakers and people who use designated decisionmakers.

As to the issue of union liability, there has been a lot of talk around here about making businesses liable. And they are liable. Small businesses and large businesses are all liable—and making HMOs liable.

If you are a union employee and have a union plan, and your union tells you you can't get some sort of treatment that you need and should get, unfortunately, the way the bill was originally drafted, you would not have been able to sue that union plan, any more than if you had been employed by a company, and the company had sponsored your plan, and you would be able to sue them or, under this bill, the HMO. But ironically the unions ended up, under the original draft, of being completely taken out of the picture.

The Senator from Ohio and the Senator from Maine made clear that was not their intent. I understand they are going to adjust some language so union plans, which are in the same basic position as those plans which are self-funded and self-administered, will be the ones which are taken out of the liability picture. That is reasonable. That is the way it should be. We look forward to that modification.

Another issue that this bill raised, which has not been really talked about at all, is the fact that it basically has Federal usurpation of what has been a very traditional State responsibility of determining the viability of the insurance agency, whether the insurance agency has adequate financial strength to cover the projected losses which may occur. This has been something on which States have spent a huge amount of time. It is a real specialty. It is an art form to look at these insurance companies and determine whether

or not they have the depth and the ability to cover the costs if they get hit with a whole series of claims.

I would hate to see the Federal Government step into this arena where the States have been responsible and suddenly take it over. But under this amendment, as originally drafted, that would be the case; the Federal Government would now basically take all that responsibility away from the States.

We discussed this with the Senator from Maine and the Senator from Ohio and their staffs to try to straighten this out. They recognize the issue.

I think the Frist model in this area is the right model. It essentially says: Where the States have responsibility, where they are the insurer, then they will have the ability—and retain the ability—to evaluate the insurer. But where it is a new Federal cause of action, a new Federal event, then the Federal Government will come in and do the evaluation. That seems to be a reasonable bifurcation of responsibility and will be an improvement if it is accepted.

I understand language is being developed which hopefully will be accepted. That is all very positive, in my opinion.

As I mentioned, this amendment, if we can get these issues worked out—and there are one or two other small ones—becomes a much more positive event for moving the bill in the right direction. The question becomes: What do we have left to do in that we have taken up a lot of amendments? Unfortunately, we still have a lot of amendments to go. Most of them are in the liability area. Some of them are in tangential areas. But I do expect we will have amendments, as we move into the evening, which will address such issues as the small employer who decides to cash out their employees and what type of protection they get. Senator ENZI happens to have that amendment.

There will be amendments dealing with class action suits. I think Senator DEWINE actually has an amendment in that area. There will be amendments dealing with coverage and liability. I have an amendment on punitive damages which essentially says if an employer lives by the terms of the external review, they should not be subject to punitive damages. There are a variety in that area. There will be amendments on forum shopping. I think Senator SPECTER has an amendment in that area that he may bring forward.

So there are still a fair number of issues, especially involving the liability questions, which have to be resolved, after we get past the language which the Senator from Maine and the Senator from Ohio have brought forward, which, as I mentioned, I think with some adjustment—which is major to the amendment, but which would be positive; and it appears to be acceptable to the sponsors—hopefully, will move the process in a better direction.

At this time I will yield to the Senator from Wyoming such time as he may need from my time.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. If the Senator from Wyoming will yield for a brief inquiry of the Republican manager, it is my understanding that because of some people being at the White House and a conference that is going to be held by the minority at 3 o'clock, the minority does not wish to vote until 3:45 or 4 o'clock.

Mr. GREGG. I believe there is still approximately an hour and a half left on the amendment. I would hope that once we reach an agreement, and we have the language from Senator SNOWE and Senator DEWINE relative to the issue of coverage for union plans and liability—and State versus Federal responsibility for reviewing the adequacy of liability, and there is one other issue—once we have that language, I personally would think we could start yielding back time and go to a vote.

I think it would be hard to get to a vote before 4 o'clock because of other commitments. It would be my hope we could vote at around 4 o'clock on this amendment.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Mr. President, this bill is really a strange one for me to be working on at all. Wyoming has one HMO. It is owned by some doctors. So far as I know, there are not any complaints on it. But there are some basic problems here that people in Wyoming are asking about.

Because of Wyoming's makeup, I usually talk about small companies, because under the Federal definition of ''500 employees or less,'' we do not have a single company headquartered in Wyoming that would be considered ''big business.'' But on this amendment I have to talk about big business.

I have been hearing from the accountants of a number of these companies. They are a little bit concerned about what is going to happen to their health care. They work for those companies. They can see what the costs are going to be on their companies. I have to say that this amendment before us now does not address the problem. I would like to think that it did.

I would like to be able to pass this. I would like to not have to talk about a big company. There are the Caterpillers and Motorolas and the Pitney Bowes and the Hewlett Packards. There are about a dozen of these big companies in the United States. Again, none of them is headquartered in Wyoming. I am pretty sure that none of them operates in Wyoming. But I am still concerned about them because there are 6 million people who get their insurance that way.

I would suspect that almost everybody in this Chamber, with the exception of my friend from Wyoming, has one of these big companies in their State. Six million people are getting their insurance from these companies.

What we are talking about is having a designated decisionmaker. It does sound like baseball season, doesn't it?

Let me tell you how this insurance works. Right now they work it in-house. They are able to keep their administrative expenses down to 5 percent. Now they are faced with the possibility of having liability. These are the companies that are providing the Cadillac insurance in this Nation.

I am not aware of complaints of these companies on their insurance. The insurance these people have is far better than the plan we have in the Senate. But they are self-funded, and they are self-administered. Where they make their big savings is in self-administration.

Now we are talking about having a designated decisionmaker. That means they are going to shift the administration to somebody else, which might still be done at 5 percent, but there is this new liability factor that goes with it. The guy that is over here, who is the designated decisionmaker, is going to have to charge them for his potential liability in the decisions that he makes incorrectly. He will not do that for 5 percent. He will need a lot more because what he is selling is liability insurance. So it is going to drive up the costs.

I have asked some of these companies what those costs would be. They have said that, quite frankly, what they will have to do is get group plans for their employees that have less benefits, to fit in the same cost level that they have right now, because this little bit of a liability factor drives up the price astronomically. So in this particular provision that is before us, we are not taking care of the self-insured and the self-administered.

I do have a proposal that I may offer after this one is finished, one that will provide some mechanism for them to continue to do that, and for those employees who they have, who are more concerned about their ability to sue than they are about the current benefits that they have, would have a choice. In exchange for that choice, this company would not have to hire a designated liability holder because that is what a designated decisionmaker would be.

For most of the firms that have the Cadillacs of the industry, most of them will have to change to a designated decisionmaker. That additional cost will be considerably more than the 5 percent they are currently paying to handle administration, that 5 percent that they do partly because they have employee committees that get involved in the decisions. And those employee committees are not going to want to be sued, so they are going to need some relief. I am here in the uncomfortable position of speaking up for the companies that are in your States, not mine, to protect the kind of health insurance they have at the present time and not drive up the cost, forcing them to go to a lower benefit plan with a designated decisionmaker.

This is not the solution. I hope you will pay attention to the solution when that amendment comes forward.

Mr. DEWINE. Will the Senator yield for a moment?

Mr. ENZI. I will yield on the time of the Senator from Ohio. I was just given pretty limited time.

The PRESIDING OFFICER (Mrs. LINCOLN). Who yields time? The Senator from Wyoming still has the floor.

Mr. ENZI. I yield the floor and reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time? The Senator from Maine has approximately 7 minutes remaining.

Ms. SNOWE. Madam President, we are awaiting modifications to the underlying amendment. Unless there are any other speakers on the floor, I suggest the absence of a quorum.

The PRESIDING OFFICER. On whose time?

Ms. SNOWE. I ask unanimous consent that the time not be taken from either side at this point.

The PRESIDING OFFICER. Is there objection?

Mr. REID. I object. We have to move this thing along.

The PRESIDING OFFICER. Objection is heard.

Ms. SNOWE. I yield the floor.

The PRESIDING OFFICER. The Chair notes, if no one yields time, time is charged equally to all sides of the debate.

The PRESIDING OFFICER (Mr. DAYTON). The Senator from New York is recognized.

(The remarks of Mrs. CLINTON pertaining to the introduction of S. Res. 117 are located in today's RECORD under ''Submission of Concurrent and Senate Resolutions.'')

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, I ask that the time be charged equally between the parties since we still have time left under the agreement which is before the Senate.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, I suggest the absence of a quorum and ask the time be charged equally.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. GREGG. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GREGG. Mr. President, for the edification of our colleagues, the projected order of events is that Senator GRAMM and Senator MCCAIN are going to offer an amendment which I believe is agreed to and will require no vote. We will lay aside the Snowe amendment, and then Senator ENZI is going to offer an amendment. We will debate the Enzi amendment for whatever time he requires. I am not sure it will be that long. Then Senator SPECTER will offer an amendment after laying aside the pending amendments. We will debate that and then probably go to a vote on the Specter, Snowe, and Enzi amendments later this evening—hopefully early evening.

Mr. REID. Mr. President, I would like to speak to the majority leader, but this sounds fine. It is my understanding—I have spoken with the principals; I have spoken with Senator KENNEDY and Senator SNOWE, and that matter appears to have been worked out so we can have a satisfactory resolution of that tonight as soon as Senator FRIST gets back.

Senator FRIST had to leave the Hill for a minor matter. He has some dental work that has to be done tonight. We understand that certainly. It is a valid reason for leaving.

What the Senator from New Hampshire has suggested is appropriate. We will go to another McCain amendment and then the Enzi amendment and then the Specter amendment.

Mr. GREGG. I think it is a Gramm amendment actually.

Mr. REID. There is no unanimous consent request at this time, but I think what the Senator from New Hampshire has outlined is appropriate. I will check with the majority leader. If he has any problems, I will report back accordingly.

Mr. GREGG. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. I ask that the Senator from Alaska be recognized and the time used not be charged against the time before the Senate.

The PRESIDING OFFICER. Without objection, it is so ordered.

EXPLANATION OF ABSENCE

Mr. MURKOWSKI. Mr. President, I ask unanimous consent, to be excused from the voting in the Senate because there is a wedding in the family that requires me to travel to Juneau, AK. I will try to be responsive to the leadership in whatever the calendar turns out to be. But I wanted to put the Record on notice of my absence and the reason for my absence.

I suggest the absence of a quorum.

Mr. REID. As under the previous order, I ask unanimous consent that the time be equally charged.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. GREGG. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GREGG. Mr. President, I ask unanimous consent the Senator from Wyoming be recognized to offer an amendment and that we debate that for up to 30 minutes with the time equally divided and no second-degree; that thereafter, we go to an amendment from Senator GRAMM, which I understand is agreed to, and that debate will be up to 10 minutes; then we go to an amendment from Senator SPECTER.

Mr. REID. Reserving the right to object, we have been told the Gramm amendment is substantially agreed to but one or two other people have to look at it first. I am sure that will work out fine.

Mr. GREGG. I didn't say it was agreed to; I just said they had 10 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is temporarily set aside, and the Senator from Wyoming is recognized.

AMENDMENT NO. 840

Mr. ENZI. Mr. President, I call up amendment No. 840.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Wyoming [Mr. ENZI] proposes an amendment numbered 840.

Mr. ENZI. Mr. President, I ask unanimous consent reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide immunity to certain self-insured group health plans that provide health insurance options)

On page 172, between lines 15 and 16, insert the following:

**SEC. 304. IMMUNITY FROM LIABILITY FOR PROVISION OF INSURANCE OPTIONS.**

(a) IN GENERAL.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 302, is further amended by adding at the end the following:

''(p) IMMUNITY FROM LIABILITY FOR PROVISION OF INSURANCE OPTIONS.—

''(1) IN GENERAL.—No liability shall arise under subsection (n) with respect to a participant or beneficiary against a group health plan described in paragraph (4) if such plan offers the participant or beneficiary the coverage option described in paragraph (2).

''(2) COVERAGE OPTION.—The coverage option described in this paragraph is one under which the group health plan, at the time of enrollment or as provided for in paragraph (3), provides the participant or beneficiary with the option to—

''(A) enroll for coverage under a fully insured health plan; or

''(B) receive an individual benefit payment, in an amount equal to the amount that would be contributed on behalf of the participant or beneficiary by the plan sponsor for enrollment in the group health plan (as determined by the plan actuary, including factors relating to participant or beneficiary's

age and health status), for use by the participant or beneficiary in obtaining health insurance coverage in the individual market.

''(3) TIME OF OFFERING OF OPTION.—The coverage option described in paragraph (2) shall be offered to a participant or beneficiary—

''(A) during the first period in which the individual is eligible to enroll under the group health plan; or

''(B) during any special enrollment period provided by the group health plan after the date of enactment of the Patients' Bill of Rights Plus Act for purposes of offering such coverage option.

''(4) GROUP HEALTH PLAN DESCRIBED.—A group health plan described in this paragraph is a group health plan that is self-insured and self-administered prior to the general effective date described in section 401(a)(1) of the Bipartisan Patient Protection Act.''.

(b) AMENDMENTS TO INTERNAL REVENUE CODE.—

(1) EXCLUSION FROM INCOME.—Section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans) is amended by adding at the end the following:

''(d) TREATMENT OF CERTAIN COVERAGE OPTION UNDER SELF-INSURED PLANS.—No amount shall be included in the gross income of an individual by reason of—

''(1) the individual's right to elect a coverage option described in section 502(o)(2) of the Employee Retirement Income Security Act of 1974, or

''(2) the receipt by the individual of an individual benefit payment described in section 502(o)(2)(A) of such Act.''

(2) NONDISCRIMINATION RULES.—Section 105(h) of such Code (relating to self-insured medical expense reimbursement plans) is amended by adding at the end the following:

''(11) TREATMENT OF CERTAIN COVERAGE OPTIONS.—If a self-insured medical reimbursement plan offers the coverage option described in section 502(o)(2) of the Employee Retirement Income Security Act of 1974, employees who elect such option shall be treated as eligible to benefit under the plan and the plan shall be treated as benefiting such employees.''

Mr. ENZI. Mr. President, we have spent more than a week debating this version of a Patients' Bill of Rights which would affect the health care coverage of more than 160 million working families who are currently provided insurance by employers on a voluntary basis. We have specifically debated the matter of protecting employers from the new liability in the bill. To that end, Senators GRAMM and HUTCHISON offered an amendment that mirrored the employer protection provision of Texas law by completely carving it out. That amendment was unfortunately defeated. So we are still in the same predicament. We have employers that are providing health care coverage that may think twice about doing so if this bill passes as it currently reads.

Now everyone, including the sponsors of the bill, acknowledges that this bill's stab at an employer protection from frivolous lawsuits needs to be fixed. The Senators are now talking about how we protect the good actors. Those are employers that are doing right by their employees, offering health coverage but not playing a role in denying medical care to which their employees are entitled under the insurance contract.

My hope is that in the course of these discussions everyone will settle on a comprehensive liability fix that includes the designated decisionmaker model presented in the Frist-Breaux-Jeffords bill. As many of my colleagues have said, that certainly seems to do the job. I agree it certainly seems to. In fact, I agree that the designated decisionmaker mechanism must be part of an amendment to successfully resolve the problems in the underlying bill.

However, while the designated decisionmaker model does present itself as the most reliable proposal for protecting most employers, there remains a small segment of the market that will continue to go unprotected. Ironically, this handful of employer health plans may represent the best of the best. These are the plans that we all should envy. They are plans better than we have in the Senate. They are referred to as the self-insured, self-administered employer plans. They comprise roughly 5 percent of the entire ERISA market.

Five percent is not a small number because that is still 6 million people, but the problem under the Kennedy-McCain direct participation model and even a designated decisionmaker model as we have been debating in the last few minutes is that these employers will have to dramatically alter their health plan because they do the plan administration in-house. That means they are participating in everything, and it means they cannot just designate their third party administration or insurance company because they don't currently contract with such entities for the purpose of processing claims. That is the difference between the self-administered and the fully insured employer plan.

We can reasonably expect the fully insured employer plan to be able to designate the final decision on a claim for benefit because that is generally how they function now, having the insurance company administer the plan, with the employer participation ranging from full plan design to advocating for a sick employee. But that is not the way the self-administered plan operates. So none of the proposals protects them.

My fear is that none of the proposals even preserves that kind of a plan. Let me explain why that is a problem. These companies that self-administer are few and far between, probably a dozen in the entire United States. But they are the big companies, the companies that operate probably in everybody's State but mine. Usually I am the advocate for small businesses because all of my businesses are small. There is not a single company headquartered in Wyoming that would be considered big business by the Small Business Administration. This issue has come to my attention from companies that participate all over the United States, and they have brought me the stories of how it will affect their plan, what the costs will be. It does require a fair bit of capital to administer a health plan and also requires that the employer wants to be actively involved in the caliber and range of benefits their employees receive. They receive more benefits than almost anyone else. And they want to design a wide, often unique range of benefits to suit the specific needs of their employees. Because the employers have the in-house resources to do so, they are actually able to be more cost-effective in what they provide than if they provided a fully insured health plan. They would rather have the health benefits than the administration benefit. It is not that they can just provide the same benefits cheaper and more efficiently; they actually provide a richer benefit package for less.

The benefits some of these employers provide include extensive mental health counseling, on-site wellness clinics, routine screenings, they include cancer, osteoporosis, and domestic violence counseling, and the list goes on. These employers often use employee review boards to evaluate disputed claims for benefits, which is also a practice used by a number of employee union operated health plans. These are clearly benefits and administrative practices designed to help employees get the highest quality health care available. In fact, these employer plans are often referred to as the Cadillac of plans. As I said before, isn't it ironic that these are the health plans hardest hit by this bill? That doesn't make any sense to me. And it clearly doesn't make any sense to me to leave these employers unprotected as we identify a way to protect employers.

For that reason, the amendment I offer today is a solution that I think is reasonable and will force us to ask ourselves a few tough questions about the purpose of a Patients' Bill of Rights. The amendment would require a self-insured, self-administered employer to offer their employees one or both of the following options, in addition to the self-administered, self-funded plan, and thereby gain a ''shield'' around that self-administered plan from the new cause of action. The logic of this amendment is to provide employees with the option of choosing a different health plan, which would also afford them access to a cause of action. The employee chooses if he or she wants that to be a component of their health benefit.

Under the amendment, self-administered, self-insured employers would be required to offer at least one of the following options. The first would be a fully insured product, under which an employee could exercise the cause of action in this bill against the insurance company administering the health plan; or, the employer would provide the option of receiving, in the form of an ''individual health benefit,'' the amount of their employer's annual premium contribution under the self-

administered employer plan. This would have to be used to buy health care, which is done in the State regulated individual market. They have the right to sue.

If an employer offers one or both of these choices to employees, then the employer would not be subject to the new cause of action under the Patients' Bill of Rights. Any new civil monetary penalties would apply to these employers for violations of the act, and the external appeals determination would be binding on the employer, but enrollees would not be able to pursue damage awards against the employer under the new cause of action. As under the Frist-Breaux-Jeffords bill, this provision would not preempt any medical malpractice action currently available in state court.

It would not do that. This is very clear. An employee makes the choice to either keep the caliber of benefits under the self-administered plan, or to choose a plan specifically for the right to sue. Those employees that choose the fully insured product will be able to hold their plan accountable under the new cause of action. And, those employees that choose to purchase their own plan through the ''individual health benefit'' are similarly able to hold their plan accountable under state law.

The argument has always been that ERISA is unfair because it ''traps'' employees in the employer sponsored plan, affording that option alone, where damage lawsuits aren't available. This proposal solves that dilemma without jeopardizing access to top-notch employer sponsored health care for those employees. Have any of you been hearing from the major companies that provide the self-insured, self-administered employer plan? No, you have not. They have not been asking for that right to sue. They like the range of benefits they have. They like the personal way it is handled.

The arguments you will hear against the amendment, I believe, actually make the case for it. It is very simple. It will be argued that employees will never be able to get the rich benefit packages that their employer's self-administered plan currently provides if they opt into the individual market by taking the ''individual benefit,'' and, while it may be better than the individual market under the fully insured option, surely it won't compare to the self-administered option.

That is absolutely right. If they spend the same amount of money and add a liability part to it, you do not get as much insurance. I am trying to preserve their insurance, not the right to sue, by giving them the flexibility. Any employer that ever had a bad actor incident in their company would have all of their people go out into the individual market under this plan.

This bill would eliminate the best employer plans out there because we feel compelled to sue them instead of making the decision to eliminate self-administered plans by a lawsuit from Washington. Why don't we let the employees make the choice for themselves? Every time a window of choice comes open they can opt into this other plan if they think it is a good way to go.

But I will tell you why the businesses cannot do what is being mandated under this bill. If they have to have a designated decisionmaker, they are hiring somebody to take the liability risk. They are not just hiring somebody to administer the plan. That is only a 5-percent cost. This will drive their prices up dramatically if we do not give this option, and people who are receiving the best care in the United States at the present time will have to settle for something else.

I believe we have made a concerted effort through the amendment. It is one we talked about a lot last year in the Patients' Bill of Rights conference committees. We made an attempt to amend the process, to remedy the problems of the entire liability section under the underlying bill, including protecting employers and including protecting small employers.

It is not worry about the small ones; this is worry about the big ones who are providing the best of the best. I do not believe we will be doing a good job unless we include this amendment.

I yield the floor and reserve the remainder of my time.

The PRESIDING OFFICER. If no one yields time, time will be charged against both sides.

The Senator from North Carolina.

Mr. EDWARDS. Mr. President, I understand what my friend from Wyoming is trying to do. We appreciate his work on this issue. This is a subject matter that was covered previously by the Snowe-Nelson-DeWine-Lincoln amendment on which we reached consensus on the floor a few hours ago. That amendment was specifically designed to strike the proper balance between protecting employers on the one hand and making sure we also protected the rights of employees. So this is an issue that has already been covered, about which there has already been great discussion, work, and compromise across party lines, Democrats and Republicans, and about which we are soon to have a vote. It is an issue about which we already have consensus. We have widespread support for that consensus.

The reason for that widespread support is we have protected employers while at the same time kept alive the rights of employees and patients. We have struck in a very creative way a solution to that problem.

This specific amendment has at least two major problems. No. 1, what it does is take away the rights of employees, patients, and families, to hold anybody accountable if one of two things occurs. The problem with that concept is that it is in violation of the President's principle, which we have talked about at great length on the floor of the Senate, which is that employers be protected but that somebody be held accountable if the employee, the patient, is injured as a result of a medically reviewable decision. The President specifically said that in his principle. That principle is completely complied with in the Snowe-DeWine-Nelson amendment because in that amendment we create a situation where we protect the employees right to recover if, in fact, they are injured by a medically reviewable decision, while at the same time providing protection for employers. So that is the reason that consensus was reached. That is the reason both Democrats and Republicans support it across party lines, and that consensus is consistent with the President's principle.

This is an issue about which we have already talked and an issue about which we have reached some agreement.

In addition to that, there are at least two other problems with this specific amendment.

No. 1, it provides the employees with a false option. It says for self-insured, self-administered plans, if either of two things occurs, the employee, the family, and the patient lose their right to hold anybody accountable. One of those options is that they go out, get a voucher, and buy their own health insurance. But there is absolutely no requirement that the voucher be adequate to buy quality health insurance plans.

Second, they may provide a comparable plan. But there is nothing to require that the benefits of that plan be equal to the benefits the employee would otherwise have.

The bottom line is there are no protections that require that under these options the employee or the patient end up with the same quality health care plan. In many regards, it is a false option that is being provided to them.

Another fundamental problem is that there is a provision in the amendment—this is the B–1 exclusion from income—which says section 106 of the Internal Revenue Code of 1986 is amended by adding at the end the following. Of course, an amendment to the Internal Revenue Code creates a blue slip problem. This issue has to originate in the House, which means, if adopted, that this entire legislation could be sent back to the Senate from the House.

We have a number of problems. I understand what my colleague is trying to do. I think his purpose is very well intentioned. But I say to my colleagues, No. 1, this is an issue about which we have already reached consensus in the Snowe-DeWine-Nelson amendment. We have reached that consensus for an important reason. We have complied with the President's principle. We have complied with the fundamental principle, with which many of us on both sides of the aisle

agree, which is we need to protect employers and provide the maximum protection for employers but, in that process, not leave the patients behind. That is the reason we have an amendment to be able to reach consensus.

No. 2, the choices that are being provided in this particular amendment we believe are false choices, and they would not require that the employee or the patient receive the same quality plan they would get with the employer.

No. 3, it creates a blue slip problem, which means the entire Patient Protection Act could be sent back to the Senate since it involves an amendment to the IRS Code.

There are a number of fundamental problems. I appreciate my colleague's work on this issue. I think this does not move us in the right direction. We have an amendment that already addresses this issue. It is an amendment that provides protection for employers while at the same time keeping alive the rights of patients and employees.

I urge my colleagues to vote against this amendment.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

The Senator from Wyoming.

Mr. ENZI. Mr. President, I want to quickly refresh the memory of the Senator from North Carolina.

I would not have entered into the time agreement had I known he wasn't listening when I debated the Snowe-DeWine arrangement where I clearly pointed out that it is not considered thereunder. I think this is a sticking point that the President would see as being very difficult.

We are talking about companies such as Hewlett-Packard, Firestone, Motorola, Caterpillar, Pitney Bowes—big companies that are providing this. I have checked on the costs. Their costs will go up from $40 million to $70 million if the Snowe-DeWine amendment is the only defense they have.

I yield the remaining time to the Senator from Texas.

Mr. GRAMM. Mr. President, first of all, this problem has not been fixed. The amendment we will adopt is window dressing and has no impact on this problem. What the Senator has proposed is a solution to an assault on the best health care plans in America. The biggest companies with self-insured plans that employees love will be destroyed by this bill.

All the Senator is saying is that if Wal-Mart employees love their plan, and they want to keep it and agree to not require Wal-Mart to be liable to be sued, and if Wal-Mart gives them the option of going into a fully-insured plan with liability so that they do not have to be in the Wal-Mart self-insured plan, they can choose to remain in it, and Wal-Mart will not be forced by liability costs to cancel their plan. This is an important issue that addresses a very real shortcoming in this bill. The incredible paradox is that this bill will do the most damage to the best health care plans in America—plans that are self-insured, that are large, and that provide terrific coverage. Under this bill, there is no question about the fact that the employer will be held liable. That liability fear will end up forcing them out of these plans.

The Senator has offered us a third way. The third way is if every employee is offered an alternative where there is liability available, then those who choose to stay in their health plan and say, I love my Wal-Mart plan and I don't want to sue Wal-Mart, would have a right to do it. That is what the Senator's amendment does. All of the rest of these arguments have nothing to do with the amendment.

Do you want to destroy the best health care systems in America? If you do, you want to vote against the Enzi amendment. If you do not, vote for the Enzi amendment which guarantees that a Wal-Mart employee will have an option of another health care plan where everybody is liable. But if they choose a better plan with fewer lawsuits, aren't they better off by definition by choosing?

The Senator from North Carolina says if you do not get lawsuits, you ought not to be happy. Maybe not everybody agrees with the Senator from North Carolina.

I yield the floor.

The PRESIDING OFFICER. Who yields time?

Mr. GREGG. Mr. President, what is the time situation?

The PRESIDING OFFICER. No time is remaining on Senator ENZI's side, the sponsor of the amendment, and 8 minutes 44 seconds remain in opposition to the amendment.

Mr. GREGG. I understand the Senator from Texas has an amendment, which has been agreed to by both sides, and she needs about 3 minutes to present it. Is there any objection to setting aside the Enzi amendment and allowing the Senator from Texas to go forward?

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Texas is recognized for 3 minutes.

AMENDMENT NO. 839

Mrs. HUTCHISON. Mr. President, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Texas [Mrs. HUTCHISON], for herself and Mrs. CLINTON, proposes an amendment numbered 839.

Mrs. HUTCHISON. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To include information relating to disenrollment in the information provided to patients)

On page 101, between lines 14 and 15, insert the following:

(3) DISENROLLMENT.—Information relating to the disenrollment of a participant, beneficiary, or enrollee.

Mrs. HUTCHISON. Mr. President, this amendment is a very simple one. There are several things that must be reported to an enrollee in a plan before the company can implement those things. They are major changes to that person's plan because you don't want a person to go into the doctor's office or into the pharmacy and be told they have been dropped from their insurance or that their spouse has been dropped from their insurance or their child.

We are requiring under the basic bill 30-day notice of any material change. My amendment just specifies disenrollment as one of those items that must be given 30 days' notice.

I have had an experience in which a person's husband was dropped from a plan, was not told about it, and found out when the person went to pick up a prescription drug for the husband, and had no way to fight it in the pharmacy. Later in the week, when the person called to find out why the husband was dropped from her plan, they found it was a mistake. Of course it was a mistake.

So that is why you want the 30 days' notice, so that a person would not have to find out that they are not getting coverage they thought they had through a clerical error.

That is all this amendment does. I urge its adoption.

The PRESIDING OFFICER. Who yields time?

Mr. GREGG. Mr. President, I ask unanimous consent that the amendment be agreed to.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The amendment (No. 839) was agreed to.

Mrs. HUTCHISON. Thank you, Mr. President.

The PRESIDING OFFICER. The Senator from North Carolina.

AMENDMENT NO. 840

Mr. EDWARDS. Mr. President, let me respond briefly to a couple of the comments that were made about the Enzi amendment.

First of all, no argument was made that I heard about the blue-slip problem, so I presume there is agreement that if this amendment is included, it would require the entire Patient Protection Act to be sent back.

Second, I say to my friend from Wyoming, I actually did listen to his comments in the debate. And not only that, I sat in hours of meetings with Senators SNOWE and DEWINE, and others, working out the language of the Snowe-DeWine-Nelson amendment.

The Senator is factually incorrect about one thing; that is, that what Snowe-DeWine-Nelson does is, No. 1, provide complete, 100-percent protection for 94 percent of the employers in the country. Almost every small employer is totally protected. But we left rights in place for patients. The employers are completely protected.

For the self-insured, self-administered employers, we have also provided

specific protections in this amendment, which we have been working on for several days now. No. 1, they are completely carved out. Self-insured, self-administered plans are totally carved out of the Federal cause of action in the Bipartisan Patient Protection Act. They cannot be held responsible for contractual, administrative responsibilities, period. They are out.

Second, we have provided that if they choose to do so, they can pick a third party designated decisionmaker and send all liability to that decisionmaker by which they are completely protected.

And finally, we have provided that if they have what many of these large employers have, which is a system where they simply make a decision, yes or no, on paying the claim after the treatment has already been provided—that the patient goes and gets the treatment; then they decide whether they are going to pay for it or not—they cannot be held responsible.

So I say to my friend and colleagues, what we have done is provide complete protection for 94 percent of the employers in this country in the Snowe amendment, while at the same time not removing the rights and protections of patients.

For the self-insured, self-administered employers, we provided three protections: No. 1, they are completely out on the Federal cause of action, which is contracts, administrative issues.

No. 2, we have specifically said they can use a designated third party decisionmaker and remove all liability by doing that if they so choose.

No. 3, we have said if they operate the plan by saying: we decide after the treatment just simply whether we are going to pay for it or we are not going to pay for it, they are completely protected.

So after lots of work, and many hours, I say to my colleagues, we believe we struck the right balance in both cases—for providing maximum protection for the employers and keeping in place the rights of patients, employees, and families.

So in addition to the blue-slip problem, which in and of itself would be enormous, we believe that we have dealt with this issue. We have dealt with it in a proper and adequate fashion. And we have addressed the concerns of the self-insured, self-administered plans, and the issues raised by small employers around the country who will be completely protected by this amendment.

I yield the floor.

The PRESIDING OFFICER. Who yields time on this amendment?

The Senator from Wyoming.

Mr. ENZI. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. It is my understanding that the managers of the bill, including Senator FRIST, would ask that this vote be put over until a later time. So I ask unanimous consent that be the case.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Chair advises the Senator from North Carolina he has 4 minutes remaining in opposition to this amendment.

The Senator from Texas.

Mr. GRAMM. Mr. President, under the previous unanimous consent agreement, I believe I had 10 minutes to offer an amendment with Senator MCCAIN, but he is not here. I am waiting for him to come back. So I would just like to suggest that perhaps we could modify the unanimous consent agreement so that when he does come back, whoever is speaking at that point, whenever they are finished, we would be recognized to do the amendment. But there is no reason we cannot conduct other business while we are sitting here.

Mr. KENNEDY. Why not talk now?

Mr. GRAMM. I am offering this with Senator MCCAIN. I think he wants to be here as well. It is my understanding he is on his way.

Let me just suggest we let Senator NICKLES speak, if he would like to speak. We could all learn something from listening to him. And then, when he is finished, hopefully Senator MCCAIN will be back, and we will do this long-awaited amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Oklahoma is recognized.

Mr. NICKLES. Mr. President, I just appreciate my friend and colleague from Texas. I will be very brief. I understand the Senator from Pennsylvania wants to come and speak on his amendment. I would just like to make a couple general comments.

Just for the information of our colleagues, I believe at—6:30 we will have three votes. So people should be cognizant of the fact we are going to have two or three votes—three votes, I believe—at around 6:30.

One, I wish to compliment the Senator from Wyoming, Mr. ENZI, for his enrollee choice proposal. I think it is an outstanding proposal. I urge my colleagues to be in favor of it.

I would also like to make a couple comments dealing with the designated decision maker. Some people are acting like this is a grand compromise, that this is going to save employers: Employers are going to be exempt now because we are going to give this decision to a third party.

When I ran a company, Nickles Machine Corporation, we had a third party administrator. They handled all the administrative claims. They did a decent job. So I didn't have to do it, our company didn't have to do it. We hired them to pay the benefits, to harass the providers, to make sure that benefits were paid or weren't paid. They paid the right benefits, didn't pay the right benefits. They were hired guns to run the plan, to make the decisions, to negotiate with the hospitals, negotiate with the doctors—all those kinds of things. That is what third party administrators do.

Now we are talking about saying: They have that responsibility, and now they have liability, too. That's what this amendment does. Some people said: It is going to hold employers harmless. It will not. I will tell you, the net result is third party administrators are going to say: What am I liable for? Under the McCain-Kennedy-Edwards proposal, they are liable for anything and everything. They are liable for unlimited economic damages. They are liable for unlimited noneconomic damages, pain and suffering. They are liable for punitive damages—up to a cap of $5 million—in Federal courts. They are liable for unlimited economic and noneconomic damages in State courts.

It has never been said that State court limitations for doctors and so on would apply to the plans and/or to the States. So now we are saying to a third-party administrator, we want you to assume the liability but the extent of the liability is not defined. It is unlimited. One good lawsuit and they are going to have to write a great big check. What are they going to do? They are going to have to charge a lot of money. They are going to have to charge as much money as they think this will cost, and they are going to guess because they don't know.

It is kind of like playing Russian roulette. They might be lucky and not have any suits so whatever they charge will be profit. Conversely, if there is one bad suit and they are found liable, they are assuming this liability and they could go bankrupt. So they are going to be trying to err on the high side.

The net result, for everybody who thinks this is going to exonerate employers and all they have to do is designate somebody else to accept their liability, I tell my colleagues, as an employer, that is not going to happen. An employer may say: You handle this, third party; you assume our liability. And that third party is going to say: OK, but I am going to charge you for it, and I am going to charge you more than enough to make sure that we don't go bankrupt in the process.

Maybe they can buy insurance themselves or maybe they can't. My guess is we are going to find out. Some people have said: CBO says that the liability provision under this bill is .8 percent. I would be willing to bet anybody the premiums that are going to come out as a result of this liability in third party administrators assuming liability is going to be a lot more than .8 percent. My guess is you are going to be looking at premium increases of 4 and 5 percent just to cover the liability

before someone will take this because the liability is not defined. It is unlimited, unlimited noneconomic, unlimited economic.

The contract coverage, well, you may have to cover just about anything. We never did tighten up medical necessity so if somebody says maybe it should be covered, it should be covered. So you are not even confined to the contract. We don't have contracts. This third party administrator, which is usually charged with enforcing a contract, does not have a defined contract and has unlimited liability. And we tell them they have to pay for everything. They are going to end up charging the employer more than they think it would cost so they don't go bankrupt.

So we are going to find out how much this costs. My point is, I want people to be aware of the fact that just having a designated decision maker with no limitations on liability, with no limitations on covering what is in the contract can be enormously expensive.

One other fact that people haven't considered. If you are a designated decision maker and you are making these decisions on what to cover and not to cover and you are liable if things don't work out, you are hardly ever going to say no. You will hardly ever say no because if you say no, you might be sued. Therefore, you are going to have more defensive medicine than you have ever had. Whereas before they were charged with the responsibility of enforcing a defined contract—this is covered; this is not covered; being more of an administrator of a contract and a plan—they are now going to be faced with liability. And they can't afford the ultimate price of being hit with a heavy lawsuit. So when the claim comes forward, if it is even close, they are going to pay it. Pay it. Pay it. They don't want to take a risk or a gamble that they can be sued for unlimited damages. So you will have enormous increases through increase of what I would call defensive protections so people don't have liability costs.

And then you will have people guessing what the liability will be, and that will increase the cost to make sure that they have enough that they don't go bankrupt.

The net result is that this designated decision maker that some people think is going to exonerate employers will show that this is a very expensive provision, and the cost of this bill, the cost of medicine, the cost of health care and, therefore, ultimately the number of uninsured will rise dramatically as a result of this bill and because of this provision.

I urge my colleagues to vote no on the underlying amendment that deals with this provision.

I want to mention—I hope it gets fixed—I think it is outrageous we could exempt union plans from this provision. I hope it is fixed.

I yield the floor.

AMENDMENT NO. 843

The PRESIDING OFFICER. Under a previous order, the Senator from Texas is recognized, with the agreement that his 10 minutes will be equally divided, 5 minutes on either side.

Mr. GRAMM. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Texas [Mr. GRAMM], for himself and Mr. MCCAIN, proposes an amendment numbered 843.

The amendment is as follows:

(Purpose: To ensure the sanctity of the health plan contract)

Insert at the appropriate place:

Notwithstanding any other provision of this Act, any exclusion of an exact medical procedure, any exact time limit on the duration or frequency of coverage, and any exact dollar limit on the amount of coverage that is specifically enumerated and defined (in the plain language of the plan or coverage claimants) under the plan or coverage offered by a group health plan or health insurance issuer offering health insurance coverage and that is disclosed under section 121(b)(1) shall be considered to govern the scope of the benefits that may be required, provided that the terms and conditions of the plan or coverage relating to such an exclusion or limit are in compliance with the requirements of law.

The PRESIDING OFFICER. The Senator from Texas is recognized for 5 minutes.

Mr. REID. If the Senator from Texas will withhold, and no time will be charged against him, I want to propound a unanimous consent request.

Mr. President, I ask unanimous consent that Senator SPECTER be recognized to offer an amendment regarding Federal courts with an hour for debate equally divided in the usual form; further, that Senator SNOWE be permitted to modify her amendment; further, that the Senate vote in relation to the Snowe amendment at 6:50 p.m. this evening, with 10 minutes for debate prior to the vote equally divided in the usual form with no second-degree amendments in order prior to the vote; further, that following disposition of the Snowe amendment, there be 2 minutes for debate prior to a vote in relation to the Enzi amendment with no second-degree amendments in order prior to the vote; further, following disposition of the Enzi amendment, there be 2 minutes for debate prior to a vote in relation to the Specter amendment with no second-degree amendments in order prior to the vote.

The PRESIDING OFFICER. Is there objection?

Mr. GREGG. Reserving the right to object, as I understand it, as to the 10 minutes, because the amendment was itself divided into four parts, four holders of time will be given 2½ minute segments.

Mr. REID. When I read that, I knew we should have a clarification. I appreciate the Senator clarifying that.

Mr. SPECTER. Mr. President, reserving the right to object, I entered the Chamber and I heard my name mentioned. I would ask that the unanimous consent be repeated.

Mr. REID. That the Senator from Pennsylvania would have one hour evenly divided in the usual form.

Mr. SPECTER. Mr. President, I do object to that. I was asked how long I thought it would take, and I said 2 hours. Then I was asked if I thought I could do it in an hour, and I said I would do my best. This is a complicated amendment. This is a complicated bill. I am not prepared to enter into a unanimous consent request which limits my presentation to 20 minutes.

Mr. REID. Will the Senator from Pennsylvania agree to have having 45 minutes for him and 15 for us? We have Members who want to know when they are going to vote.

Mr. SPECTER. That is not satisfactory. I am being importuned over here about what a good deal it is. This amendment, Mr. President, involves a question of whether there will be both Federal jurisdiction and State jurisdiction. It is a matter I have discussed with the managers of the bill again this morning and with Senator EDWARDS. I believe there is going to have to be some discussion. There are going to have to be some issues raised and some questions answered. It simply does not lend itself to that kind of time constraint.

Mr. REID. If I could say to the Senator from Pennsylvania, how about if he has an hour and we have 20 minutes?

Mr. SPECTER. Mr. President, I am prepared to start the debate and to make it as expeditious as possible. But I am not prepared to negotiate time to an hour and 20 minutes total. I object.

The PRESIDING OFFICER. Objection is heard.

The Senator from Texas is recognized for 5 minutes on his amendment.

Mr. GRAMM. Mr. President, I have sent an amendment to the desk. The amendment has been read.

Let me explain to my colleagues what the amendment does, why it is important, and then I will thank our distinguished colleague from Arizona.

Under the bill that is now before us, under the language of the current bill on page 35, the bill says that contracts are binding. But then it makes those contracts binding unless they are subject to a judgment of medical facts and they are subject to medical review.

This creates an extraordinary ambiguity and, for all practical purposes, makes the contract not binding. That creates a situation where every health insurance company in America will realize that these outside medical reviewers, based on medical necessity, could invalidate every health insurance contract in America and, as a result, put everybody under the high option plan whether they pay for it or not. The net result would be an explosion in health care costs. In fact, if this provision is not fixed, it is at least as explosive in potential cost as the liability section, which we have talked about 10 times as much.

The amendment I have offered makes the contract binding, and it provides

language that says the contract is binding as long as the contract does not violate the language of the bill. Let me explain very briefly what that means. If, as we do under the bill, we say that if you provide emergency room coverage, you have to have a prudent layperson standard for that emergency room coverage, so you have to do that if you provide the coverage no matter what this amendment says; or if we say under the bill that if the plan has pediatric care for children, that can be the primary physician, then it would have to be the law that would govern.

Within that very limited proviso, this amendment makes the contract binding. I think it is a dramatic improvement in the bill.

I thank our distinguished colleague and my old and dear friend from Arizona for helping me work this provision out. It is something I have worried about. I do think it improves the bill, and it certainly would not have happened without the reasonableness of our dear colleague from Arizona. I thank him for that.

I yield the floor.

Mr. MCCAIN. Mr. President, I thank the Senator from Texas for causing this amendment to happen. It really is to ensure the sanctity of the health care contract. Concerns were raised that under the pending McCain-Kennedy legislation, independent medical reviewers can order a health plan to provide items and services that are specifically excluded by the plan.

That was not the intention of the law. The Senator from Texas pointed out that it could have been interpreted in another way, and clearly this amendment I think tightens that language to the point where it is clarified that the bill doesn't do this and its specific limitations and exclusions on coverage must be honored by the external reviewers.

There are numerous safeguards already in the bill to ensure that external reviewers cannot order a group health plan or health insurer to cover items or services that are specifically excluded or expressly limited in the plain language of the plan document and that do not require medical judgment to understand.

So I think this language is important in its clarification. I understand Senator GRAMM's concerns. I know this will not bring him to the point where he is willing to vote for the bill, but I do hope it satisfies many of his concerns, and we will continue to work with him to try to satisfy additional concerns. I appreciate his cooperation and that of his staff. I believe my friend from Texas would agree this is probably the 35th draft we have of this maybe 9-line amendment, but each word is important nowadays as we work our way through this bill. I believe the appropriate place is on page 36, line 5.

By the way, I thank Senator KENNEDY and Senator EDWARDS and their staffs for agreeing to this amendment. I share the opinion of the Senator from Texas that it is an important amendment.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KENNEDY. Mr. President, I urge that we accept this amendment. As in other areas, there has been a desire to provide clarification to the language we had in the bill. One of the issues that has been debated is the power and authority of the review medical officer in the review process. It was never the intention to include benefits that were not outlined in the contract. It was going to be limited to the contract, but it was also going to give discretion in terms of medical necessity. So this is a clarification of that, and I think it is a useful and valuable clarification. I hope the Senate will accept it.

Mr. GRAMM. Mr. President, I seek only to do good, not to have it recorded through a recorded vote. So I ask unanimous consent that the amendment be accepted.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The amendment (No. 843) was agreed to.

Mr. MCCAIN. The amendment that I offered today with Senator GRAMM helps to clarify the intent of how this bill deals with medically reviewable decisions.

Mr. KENNEDY. The Senate should understand that the language in the McCain-Edwards-Kennedy bill is based on language from a bipartisan compromise between JOHN DINGELL and CHARLIE NORWOOD. Every member of our conference signed off on our approach the last Congress, from DON NICKLES and PHIL GRAMM to JOHN DINGELL and me.

Our approach is based on a very important concept. It assures that the external reviewer cannot be bound by the HMO's definition of medical necessity. This does not mean that the reviewer sign off on anything that is explicitly excluded by the health plan. If the plan covers 30 days in the hospital the reviewer cannot approve 100 days. However, where a coverage decision requires medical judgment to determine whether of not what the patient is requesting is the type of treatment or services that is explicitly excluded, we intend for that determination to be eligible for independent review.

Mr. MCCAIN. The amendment we are drafting here—that merely restates what is in the underlying bill—is not intended to change our fundamental approach, just to clarify our intent.

Our overall bill still clearly states that coverage decisions that are subject to interpretation or that are based on applying, medical facts and judgment should be reviewed. This includes those decisions that require the application of plan definitions that require that interpretation.

Mr. KENNEDY. Absolutely—the reviewer should be looking at those cases. The amendment is intended to clarify that we never meant to have the independent reviewer approving a benefit that is explicitly excluded in all cases. However, in the case where there is some dispute about whether it is a medically reviewable benefit, we do want the case reviewed.

Mr. MCCAIN. Right, just as in the case we have heard about a child with a cleft palate. The plan says they do not cover cosmetic surgery, but the doctor argues that there is specific health risks for not having this surgery. That is something the independent reviewer would look at to determine if it is covered in this case.

Mr. KENNEDY. Under the bill the external review process is first designed to determine whether a denial by the plan or issuer is based on a particular definition, or a specific benefit exclusion or limitation under the plan or contract whose meaning is unambiguous and does not turn on specific medical facts in an individual patient's case. An appeal will be dismissed in cases where the entity concludes that unambiguous plan language is the basis of a denial and that no set of medical facts either could or would result in coverage under the terms of the plan.

Mr. REID. Mr. President, we are going to have a vote sometime from 6:45 to 7:15, according to how much time is taken on the Specter amendment. We will have three votes at that time. Members should be ready to come and vote at or about 6:40 or 7:15, something like that.

The PRESIDING OFFICER. Under the previous order, the Senator from Pennsylvania is recognized to offer an amendment.

AMENDMENT NO. 844

Mr. SPECTER. Mr. President, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report the amendment.

The senior assistant bill clerk read as follows:

The Senator from Pennsylvania [Mr. SPECTER] proposes an amendment numbered 844.

Mr. SPECTER. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To require that causes of action under this Act be maintained in Federal Court)

On page 153, strike line 9 and all that follows through page 154, line 2, and insert the following:

''(10) STATUTORY DAMAGES.—The remedies set forth in this subsection (n) shall be the exclusive remedies for causes of action brought under this subsection. In such actions, the court shall apply the tort laws of the State in determining damages. If such damages are not limited under State law in actions brought under this subsection against a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan), then State law limiting such damages in actions brought against health care entities shall apply until such State enacts legislation imposing such limits against group

health plans (and issuers). Nothing in this section shall be construed to require a State to enact legislation imposing limits on damages in actions against group health plans and issuers.

On page 160, between lines 2 and 3, insert the following:

''(D) ACTIONS IN FEDERAL COURT.—A cause of action described in subparagraph (A) shall be brought and maintained only in the Federal district court for the district in the State in which the alleged injury or death that is the subject of such action occurred. In any such action, the court shall apply the laws of such State in determining liability and damages. If such State limits the amount of damages that a plaintiff may receive, such limits shall apply in such actions.

On page 156, strike lines 15 and 16 and insert the following:

subsection.

''(o) LIMITATION ON CLASS ACTION LITIGATION.—

''(1) LIMITATION.—

''(A) IN GENERAL.—Any claim or cause of action that is maintained under this section in connection with a group health plan, or health insurance coverage issued in connection with a group health plan, as a class action, derivative action, or as an action on behalf of any group of 2 or more claimants, may be maintained only if the class, the derivative action claimant, or the group of claimants is limited to the participants, beneficiaries, or enrollees with respect to a group health plan established by only 1 plan sponsor or with respect to coverage provided by only 1 issuer. No action maintained by such class, such derivative action claimant, or such group of claimants may be joined in the same proceeding with any action maintained by another class, derivative action claimant, or group of claimants or consolidated for any purpose with any other proceeding.

''(B) DEFINITIONS.—In this paragraph, the terms 'group health plan' and 'health insurance coverage' have the meanings given such terms in section 733.

''(2) EFFECTIVE DATE.—Paragraph (1) shall apply to all actions that are pending and have not been finally determined by judgment or settlement prior to the date of enactment of the Bipartisan Patient Protection Act, and all actions that are filed not earlier than that date.''.

(2) RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT.—Section 1964(c) of title 18, United States Code, is amended—

(A) by inserting ''(1)'' after the subsection designation; and

(B) by adding at the end the following:

''(2)(A)(i) No action may be brought under this subsection, or alleging any violation of section 1962, if the action seeks relief concerning the manner in which any person has marketed, provided information concerning, established, administered, or otherwise operated or provided a group health plan, or health insurance coverage issued in connection with a group health plan. Any such action shall only be brought under the Employee Retirement Income Security Act of 1974.

''(ii) In this subparagraph, the terms 'group health plan' and 'health insurance issuer' have the meanings given such terms in section 733 of the Employee Retirement Income Security Act of 1974.

''(B) Subparagraph (A) shall apply to actions that are pending and have not been finally determined by judgment or settlement prior to the date of enactment of the Bipartisan Patient Protection Act, and all actions that are filed not earlier than that date.''.

(3) CONFORMING AMENDMENT.—Section

Mr. SPECTER. Mr. President, I declined to enter into a time agreement because this is an amendment which deals with the complex subject of jurisdiction. I have long been a cosponsor for a Patients' Bill of Rights, and I was surprised to learn many years ago of the Federal preemption which precluded an injured patient—for example, where a family doctor recommended a specialist and the HMO refused to provide the specialist to the person and the person was injured, or perhaps died, and had no redress in the Federal courts because of the so-called preemption under ERISA.

It has seemed to me for many years that that was one of the problems that ought to be addressed. I compliment Senator MCCAIN, Senator KENNEDY, and Senator EDWARDS for the work they have done, and also Senator FRIST, Senator BREAUX, and Senator JEFFORDS for their companion bill, and what the managers have done here.

This amendment addresses what I believe, from my experience as a litigator in the civil courts, to be a very fundamental question of concern as to what courts these cases are going to be tried in. The very brief history of ERISA is that cases which have been brought under section 502 of ERISA are governed by what is called the doctrine of complete preemption, and that is where the cases involve contract interpretation, or so-called quantity of medical care.

Under ERISA, section 514, a plaintiff's case has been barred where it relates to an employee benefit plan, and that has been decided by the case law, and has been referred to as quality of care or medical malpractice. For many years, under ERISA, which was enacted in the 1970s, that barred any action at all. But as the courts saw the difficulty of this matter, there gradually came to be a loosening of the interpretation and noted succinctly in a Fifth Circuit opinion, Corporate Health Insurance v. The State Department of Texas, where Circuit Judge Higginbotham noted that the court had ''repeatedly struggled with the open-ended character of preemption provisions of ERISA and also the Federal Employers Health Benefits Act.''

The court noted that there had been a faithful following of the Supreme Court's broad reading of ''relate to'' in its opinions decided during the first twenty years after ERISA's enactment. Since then in a trilogy of cases, *DeBuono* v. *NYSA-ILA Med. & Clinical Services Fund*, 117 S.Ct. 1747 (1997); *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A., Inc.*, 117 S.Ct. 832 (1997); *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins., Co.*, 115 S.Ct. 1671 (1995), the Court has confronted the reality and had limited the application of that preemption so the cases were brought for medical malpractice in the State courts.

The provisions of the McCain-Edwards-Kennedy bill provide that where you have an action brought on contract interpretation or ''quantity of medical care,'' those cases will go to the Federal court, but where you have a claim which is brought for the ''quality of medical care,'' or so-called malpractice, those cases will go to the State court.

I suggest to my colleagues that to have the two courts handle the matters in that way will result in procedural quagmire because if you have a case such as the following where a child is born to a mother who has a plan under an HMO which seeks to limit the hospital stay to 24 hours. The patient is then discharged and an unfortunate result happens to the child. There will be both claims under the so-called quantity interpretation of the contract and quality on medical malpractice.

That is illustrated in the case of *Bauman* v. *U.S. Healthcare*, 1 F. Supp. 2d 420, a case which was heard in the United States District Court for the District of New Jersey in 1998. In that case, and this illustrates the kind of an issue I am referring to, the HMO plan had policies which encouraged the discharge of a mother and a newborn within 24 hours after birth. Mrs. Bauman was discharged after that time elapsed, and the next day the Baumans' daughter fell ill.

The Baumans contacted the HMO and requested a home visit by a nurse. The HMO refused to send a nurse, and the daughter died of meningitis the same day. The Baumans brought an action against the HMO, the doctor, and the hospital, and they went into State court. The HMO removed the case to Federal court as they had a right to under ERISA.

The district court made a determination that counts under the complaint relating to the discharge decision were ''quality-of-care'' decisions, and the counts would be remanded to the State court. The district court said that the failure to provide the nurse was a ''quantity'' decision and, therefore, was preempted totally.

On appeal, the United States Court of Appeals for the Third Circuit, in a case captioned In re U.S. Healthcare, Inc., 245 F.3d 266, reversed the district court holding that the claim was a quality decision.

The Bauman case illustrates the point about how hard it is to decide whether a claim is a ''quantity'' claim or a ''quality'' claim.

Under the McCain bill, the claim that the Baumans would bring if the McCain bill were enacted, would be in the Federal court on the issue of plan coverage because that is a determination of the ''quantity'' of medical care, but that the other claims would be brought in the State court. I suggest obviously that is a procedural quagmire.

The point is further illustrated by an opinion of the Court of Appeals for the Third Circuit in a case called *Lazorko* v. *Pennsylvania Hospital*, 237 F.3d 242, decided just last year, where the underlying facts show the plaintiff's wife was hospitalized for attempted suicide. She was released but continued to have

thoughts of suicide. Her doctor refused to readmit her to a hospital, and thereafter, regrettably and unfortunately, she killed herself.

In the State court, the plaintiff sued the HMO. The case was removed to the Federal court where the counts on direct liability against the HMO were dismissed. The case was then remanded to the State court and then removed again by the HMO to the Federal court.

The Federal court dismissed some of the counts against the HMO but remanded the case to the State court because of the various vicarious liability claims which the plaintiff had against the HMO. On appeal, the circuit court reversed the district court on one liability count and remanded the case to the district court.

That is legalese, obviously, and very hard to present in the course of a floor statement in a Senate debate on this subject, but it is illustrative of a point that where you have a situation where an HMO covers certain kinds of treatments for medical illness and you have a question as to the coverage, under the McCain bill that claim would go to the Federal court, but if there is a claim on malpractice, failure of the doctor to exercise ordinary care, that case would go to the State court.

There is no doubt that with the long history which the Federal courts have had on interpreting ERISA that there is going to be the first line of jurisdiction, and appropriately so, in the Federal court.

My amendment would provide that the Federal court would have exclusive jurisdiction over all of the claims. In a situation where the HMO would have its case heard in the Federal court, the Federal courts frequently will retain jurisdiction over the doctors, the nurses, and the hospital, and the other parties where the matter would ordinarily go to State court on what is called pendent or supplemental jurisdiction.

Again, it is very complicated. It does not lend itself to a short time agreement, but the upshot of it is that if you have the provisions of the McCain bill which give jurisdiction to the Federal court on contract interpretation or ''quantity of care'' and jurisdictions in the State court on malpractice or ''quality of care'', a plaintiff is going to have to go to two courts to get both of the claims adjudicated which is, as I say, a procedural quagmire.

The amendment which I have proposed would give appropriate deference to State law by providing that it would be the law of the State where the incident occurred which would govern the lawsuit. That is to say that the damages would be determined by State law and damages do vary among the 50 States.

Also, if the State had a cap or a limit on the amount which could be collected, that would be determinative when the case is brought in the Federal court.

This is very much like the diversity cases where jurisdiction resides in the Federal court, where the plaintiff is a resident of one State and the defendant is a resident of another State. A simple illustration would be if a patient from Camden, NJ, is treated in a Philadelphia, PA, hospital by a Philadelphia physician and there is an allegation of malpractice, negligence on the part of the physician and the hospital, then the resident of the State of New Jersey could sue in the Federal court with requisite jurisdictional amount, but it would be the law of Pennsylvania which would govern, or the plaintiff could sue in the State court of Pennsylvania. State courts would have jurisdiction.

Once you bring the HMO into the picture and you have what is traditionally under ERISA, it has to start out in the Federal court at least as the contract interpretation and ''quantity of care.'' That is why it is my view, my legal judgment, that it is necessary to avoid the procedural quagmire to have the Federal court have jurisdiction over the entire matter.

The question has been raised as to choice of law and venue, the question raised by my distinguished colleague from Tennessee, and I specified in the legislation that it would be the place of the incident which would determine the applicable law. Again, liability varies from State to State and venue has an important place. We want to avoid the potential of judge shopping so that the choice of law and the determination of venue would be where the incident occurred.

There is another important aspect to the litigation in the Federal court because of a feeling of a greater confidence in the Federal judicial system than in some State court judicial system. This is a touchy point, but it is one which the Judiciary Committee examined in some detail last year in considering the question of amending diversity jurisdiction in class action cases. Class action is when plaintiffs join to sue a defendant. There had been, for illustrative purposes, a case which had been denied class action status by the Court of Appeals for the Third Circuit, and the plaintiffs then went to Louisiana, to a favored county, and instituted the class action case and had the class action certified.

Diversity jurisdiction is easily defeated in a class action matter because if you have many plaintiffs, as you do in a class action, and a single defendant, all you have to do to avoid diversity jurisdiction is to have one of the plaintiffs a resident of the same State as the defendant. In order to have a diversity jurisdiction in the Federal court, all the plaintiffs have to be from a State other than the residence of a defendant.

In the Judiciary Committee report on this subject, the following facts of findings were made:

> Some State court judges are less careful than their Federal court counterparts about applying the procedural requirements that govern class actions.

That appears on page 16 of the report of the Judiciary Committee reporting this bill out at a 10–8 vote.

On the next page, page 17, appears the following statement:

> A second abuse that is common in State court class actions is the use of the class device as ''judicial blackmail.'' That is a fairly strong condemnation in citing that criticism of the State courts. I do not suggest the impugning of all State court judges everywhere. But there is a considerable difference in many States in the quality of the courts where you have electoral process in many States, contrasted with the Federal system of life tenure, where I believe it is fair to say it is generally accepted that the caliber of the Federal courts is better, at least as a generalization.

There has been a great deal of concern expressed by some about the unlimited potential that would be present in a Patients' Bill of Rights in exposing defendants, HMOs, and employers to very high verdicts which would increase the cost of health care. So there is some assurance, I think fairly stated, by having the cases brought in the Federal courts.

I think it is useful to cite a couple of other illustrations abut the underlying concern which I have about the procedural quagmire which occurs. One of the two cases I intend to cite additionally—but I shall not cite many of the other cases, and there are many illustrative of this proposition—is the case of *Pryzbowski* v. *U.S. Healthcare, Inc.*, 245 F.3d 266, decided by the Court of Appeals for the Third Circuit earlier this year. The plaintiff had back problems, sought surgical treatment, the HMO delayed a decision for months, the plaintiff went to State court, suing the HMO for medical complications occasioned by the delay. The HMO removed the case to the Federal court where the Federal court dismissed the claims against the HMO, finding that they were ''quantity determinations'' and therefore preempted under ERISA section 502. The district court also found that claims against the primary care provider were expressly preempted by section 514 and dismissed those claims, as well. The Court of Appeals for the Third Circuit vacated the findings and remanded the case to district court to make further findings. The appellate court noted that the claims against the primary care provider raised both ''quality'' and ''quantity'' issues and, on the record before it, the court could not decide which applied in this case.

So not only do you have the provisions of the pending bill, which would send a plaintiff to two different courts on what is essentially the same situation, but even have the courts unable to draw a bright line between what is ''quantity'' and ''quality.''

Another case which is illustrative of the problem is *Corcoran* v. *United Health Care Inc.*, 965 F.2d 1321, heard in the United States Court of Appeals for the Fifth Circuit in 1992, where a patient was pregnant, and her doctor recommended complete bed rest and hospitalization so that he could monitor

the fetus. The patient's doctor sought precertification from the HMO for a hospital stay. The HMO denied the request and authorized only 10 hours per day of health nurse services at home. Subsequently, the fetus regrettably went into distress and died at a time when the home health nurse was not on duty. The Corcorans, parents of the deceased child, brought suit in the State court which then had it removed to the Federal court, with the HMO arguing that they had not made a medical decision on ''quality'' but only a decision as to what benefits were covered under the health plan which was preempted by ERISA. The court concluded that the HMO gave medical advice, but in the context of making a determination about the availability of benefits under the plan, and as such the court found the Corcorans' claim was preempted by ERISA.

So there you have a curious situation of what is viewed as a medical decision but again, preemption, because it was held to relate to a determination of benefits under the plan.

The amendment would give jurisdiction to the Federal court on both of the claims so that when any one of these plaintiffs, such as a mother who is delivering a baby and has a limitation of 24 hours in the hospital and has a claim both as to coverage and as to malpractice, she could bring the case into Federal court, where State law would apply as to damages, and if there was a cap on damages in that State, that cap would apply.

I am a cosponsor of the bill and I, too, intend to support the bill. But I do believe that this sort of a jurisdictional clarification is indispensable if we are to avoid having a plaintiff compelled to litigate in two courts with that kind of multiplicity of action.

I ask the manager of the bill to engage in a discussion, if the distinguished manager would be willing to do so, or if a co-manager would be more appropriate to talk about the operation of the plan, if I may have Senator KENNEDY's attention. I direct a question to my colleague from Massachusetts and raise the issue as to whether it would be more appropriate to discuss the matter with the Senator from North Carolina on this issue, but the question I have relates to the McCain-Kennedy-Edwards bill where you have a case, taking the illustration of the underlying facts that I gave in the Lazorko case. Where you have an HMO, which covers medical care, and a woman being in a hospital for attempted suicide being released and the HMO refusing to readmit her, and thereafter she killed herself—isn't it true that the claims which were brought, say in Lazorko, which raised questions of interpretation of the plan, would be brought in the Federal court and the cases on malpractice would be brought in the State court under your bill?

Mr. KENNEDY. Mr. President, I do not expect we will be able to litigate a case on the floor. I am not familiar with the facts in that particular situation.

I suggest the absence of a quorum.

The PRESIDING OFFICER (Ms. CANTWELL). The Senator from Massachusetts does not have the floor; the Senator from Pennsylvania does. Who yields time?

Mr. SPECTER. Did the Senator from Massachusetts suggest the absence of a quorum?

The PRESIDING OFFICER. The Senator from Pennsylvania has the floor; the Senator from Massachusetts does not.

Mr. SPECTER. I do not intend to litigate a case on the Senate floor. So without referring to a specific case, I ask the Senator from Massachusetts, is it true that under his bill a claim which calls for interpretation of coverage of the insurance contract for so-called ''quality of care'' would be brought in the Federal court, and a claim which might—which would arise out of the same occurrence, which involved malpractice, or a ''quality'' case—would that not, under his bill, be brought under the State court?

Mr. KENNEDY. I say to the Senator, it is my understanding of the case, the facts we have to date with that particular issue, following the Supreme Court holdings in the Pegram case, this would be tried in the State court.

Mr. SPECTER. Madam President, I would press the question as to the interpretation of the insurance contract, which defined the rights of the parties under the contract. Isn't it plain, under your bill, I say to Senator KENNEDY, that this is a matter which goes to the Federal court?

Mr. KENNEDY. The understanding of our position on this issue is that the Supreme Court in Pegram said, when there is a dual issue involved in terms of the medical decision and the contract decision, as the Senator knows, on medical issues decided in the State contract, in the Federal courts, and where there is a mix of those, the predominance of these issues being medical, it would be tried in the State court.

Mr. SPECTER. Madam President, I suggest that is at variance with the provisions of the Senator's bill. I will cite the exact citation here.

At page 140, if I might call it to the attention of the Senator from Massachusetts, section 502 of ERISA, which is brought in the Federal court, and at the bottom, line 24:

(I) regarding whether an item of service is covered under the terms and conditions of the plan or coverage,

So that is a section where you have Federal court jurisdiction, and that would be the issue, as to interpretation of a contract to determine coverage.

I ask the Senator from Massachusetts if that is not an accurate citation of the Senator's bill?

Mr. KENNEDY. No. No, it is not. The Senator would be reading it out of context:

Cause of action must not involve a medically reviewable decision.

The Federal cause of action excludes the medically reviewable decision. That is on page 142, line 6.

Mr. SPECTER. If I might have the attention of the Senator from Massachusetts, on the preceding page, 139, section 302 talks about the ''availability of civil remedies.''

(a) Availability of Federal Civil Remedies In Cases Not Involving Medically Reviewable Decisions.

Mr. KENNEDY. Yes.

Mr. SPECTER. Going on to 140.

Mr. KENNEDY. The Senator is correct, and that is consistent with my earlier remarks.

Mr. SPECTER. If I may be permitted to finish my sentence, since I do have the floor——

Mr. KENNEDY. If the Senator wants a response, I am trying to respond to those highly technical questions the best way we can.

Mr. SPECTER. I do want a response, but not in the middle of my sentence or the middle of my question.

But to go forward here on the availability of Federal civil remedies in cases not involving medically reviewable decisions, this covers, line 24–25:

regarding whether an item of service is covered under the terms and conditions of the plan or coverage,[.]

My question to the Senator from Massachusetts: Isn't that an explicit conclusive statement that, if it is a matter of interpreting a contract as to what service is covered under the terms and conditions of the plan or coverage, that is a Federal remedy? That is what it says in black and white, doesn't it? I ask Senator KENNEDY.

Mr. KENNEDY. The Senator is wrong. That is taking it out of context. The fair way is to read the complete paragraph and go on to the next page.

Mr. SPECTER. Madam President, if the Senator cares to read the next paragraph, where he makes a claim of being taken out of context, I would be interested in hearing him read any such paragraph.

Mr. KENNEDY. I have referred to that earlier, page 142, line 6. The coverage decision depends on a medically reviewable issue. On the matters dealing with the medically reviewable issue, the Supreme Court has indicated that it would be decided in the State courts. That is essentially what we have included in this language.

Mr. SPECTER. Madam President, I agree with the general delineation that it was a medically reviewable decision. That is called ''quality of care,'' as I have said before, and is a malpractice issue. But the question which I have directed to the Senator from Massachusetts is a much narrower question.

To repeat, is this not a question on the interpretation of the contracts, specifically where an item of service is covered under the terms and conditions of the plan for coverage? That is my question. The interpretation of ''an item of service is covered under the terms and conditions of the plan for

coverage'' is a matter for the Federal court.

I believe it is plain from the language on 139 to 141 that it is a Federal matter. But if you move to an interpretation of what is medical malpractice or a breach of duty by a doctor on what is a medically reviewable decision, then that is a matter which goes to the State courts. And this legislation does not continue the preemption of existing law.

If I might have the attention of the Senator from North Carolina, Madam President, this is an issue which my distinguished colleague from North Carolina and I have been discussing for several days. And this morning in my hideaway we discussed the complications, at least as I saw them, on having the provisions of the pending bill which deal with this complex dichotomy of an interpretation of contract coverage, which is set forth at line 24, 25 on page 140 over to lines 1 and 2 on 141, which comment regarding an item of service covered under the terms and conditions of the plan for coverage which comes under the category of availability for Federal civil remedies. Then if you move over to a medically reviewable decision on medical malpractice, there is the difference.

Is my interpretation correct that the legislation provides for cause of action in different courts, No. 1? It is the coverage of the contract, or what the courts have called ''quantity'' malpractice and what the courts have called ''quality.''

Mr. EDWARDS. If the Senator would repeat the question, it is difficult for me to hear.

Mr. SPECTER. I would be glad to repeat the question. As the Senator and I were talking this morning, isn't it accurate that the courts have made a distinction in ERISA, section 502, on what is contract coverage or ''quantity'' with complete preemption under existing law?

Mr. EDWARDS. My understanding is—as the Senator said, we talked about this earlier today—that has traditionally been the case. I think there has been, I think, some erosion on that during the last few years. I think the Senator is correct. There have been a number of court rulings in that respect.

Mr. SPECTER. Madam President, I agree with the Senator from North Carolina. There has been erosion on the preemption of 514 where the courts have really seen the inequities of denying injured parties relief, and instead of being under 502 with ''quantity'', they have tried to move the cases into ''quality'' with the broader interpretation where some relief has been granted.

I am a cosponsor of the amendment. As I said earlier, one of the concerns that I candidly expressed a decade ago was my surprise over the reach of the preemption of ERISA. It seemed to me to be unfair to deny injured plaintiffs redress in the courts because of the preemptions which were really designed originally under other kinds of benefit plans and not under health maintenance organization plans. When the HMOs came into being, they took the benefit of the same kind of preemption.

But in this legislation you have the dichotomy where some cases are heard in the Federal courts as they relate to ''quantity care'' or interpretation of the contract, and other cases or the same case may be heard in the State court as it relates to a medical malpractice or the ''quality of care.''

My question to the Senator is, isn't that an accurate statement?

Mr. EDWARDS. Again, I am having a little trouble hearing you. If the Senator said that the separation under our legislation between the contract causes of action, which have traditionally been considered ERISA causes of action, go to Federal court and in the case of the medically reviewable decision cases go to State court, that would be accurate.

Mr. SPECTER. The concern I have, having gotten an understanding on the applicability of the statute, which the Senator and I are in agreement with, is, how is it going to work? I characterized it, while the Senator was off the floor, as a procedural quagmire.

If you have a case—and I cited a couple of them—where a child is born, and the mother has an HMO which encourages release from the hospital within 12 hours, and the child, unfortunately, dies—and I cited a specific case—and then you have a series of claims which were brought by the plaintiff and one of the claims involves interpretation of the contract, is that care covered by the contract?

Then if there are other claims for negligence on the part of the doctor or hospital, that would then fall under the amendment of the Senator from North Carolina under State court jurisdiction.

I cited another case where you had a woman who was suicidal, she was released from the hospital, the doctor wanted to put her back in, and the HMO wouldn't let him do that. She committed suicide. A suit was brought and the HMO defended it on the ground that it wasn't covered. That went from the Federal court. They dealt with the exclusive preemption under 502. But the aspect of ''quality of care'' is a State court action. You have perpetuated that.

It is very difficult, obviously, to move totally away from Federal jurisdiction under ERISA on the interpretation of the contract because there is so much law on the subject. I know my colleague will agree with me on that generalization.

What happens when you have the suicide? The mother of the infant is released from the hospital within 24 hours, and the claims are made. They are essentially the same claims. They are claiming that they are covered under the contract. They are claiming personal injuries, loss of earning potential, or for the woman who has committed suicide, loss of earnings, loss of consortium, the whole range.

Having litigated some of these cases, you more recently than I. But the essential claims are going to be the same: Personal injuries for both the claim for coverage and ''quantity of care'' as opposed to the claim for ''quality of care'' or malpractice.

So how is it going to be resolved with two separate courts, Federal court having jurisdiction over ''quantity,'' and State court having jurisdiction over ''quality?''

Mr. EDWARDS. I think——

The PRESIDING OFFICER. The Chair reminds Members to address each other in the third person and to address the questions through the Chair.

Mr. SPECTER. Nunc pro tunc.

Mr. EDWARDS. I would answer the Senator's question by saying that under the examples given, if I understood them correctly, most of those examples would involve interpretation of contract language in the context of a medically reviewable fact.

So I believe under our legislation those, in fact, go to State court. I say to my colleague, if there is any medical fact interpretation involved, I believe those cases go to State court. So I think under the examples given, all of the cases would end up in State court.

Having said that, though, in fairness to the Senator, I can imagine circumstances—I don't think the Senator's examples meet it—where there could be a medically reviewable decision which would go to State court and also there could be a claim that the contract was breached separate and apart from that, which I think is the issue the Senator is raising.

Mr. SPECTER. Madam President, I would accept the modification by my colleague from North Carolina. I think the citation I gave has a contract claim. But rather than disagree about that, since the Senator from North Carolina acknowledges there could be some cases, I will take another case whereas the Senator from North Carolina says there could be that kind of distinction.

I ask the Senator, through the Presiding Officer, then in your bill what do you do in that situation where you have the Federal court controlling—in the language of the statutes—''whether an item or service is covered under the terms and conditions of the plan or coverage'' and other aspects of the same set of facts are covered under medically reviewable factors?

Mr. GREGG. Madam President, will the Senator yield for a question?

Mr. SPECTER. I would be glad to yield as soon as I get this answer.

Mr. GREGG. It is just a technical question. The answer might be better if he has time to think about it.

Mr. SPECTER. Well, it is too late now to retain the continuity without yielding, so I do yield.

Mr. GREGG. I thank the Senator and apologize for breaking the continuity. I

think building the record on this issue is very important.

We are trying to get a sense of the situation, so we can tell our membership what they are going to be doing this evening. After your amendment is completed, we will have three votes lined up. I wonder if we could agree that we would begin the vote on those amendments at sometime around 6:45.

Mr. SPECTER. Madam President, I am not able to specify when because the Senator from North Carolina and I are in the midst of what I consider to be an important colloquy. But I will try to keep it as brief as possible.

Mr. GREGG. I thank the Senator.

Mr. SPECTER. The question, Madam President, that I ask the distinguished Senator from North Carolina is, in taking his conclusion that there are some cases which would involve contract interpretation, and the same case would involve a medical malpractice determination, what do you do when the contract interpretation has jurisdiction in the Federal court and the medical malpractice has jurisdiction in the State court?

Mr. EDWARDS. Madam President, I would say, in answering my colleague's question, that in fact I am having difficulty imagining a case right now. The vast majority of cases similar to what we have just been discussing would fall within the category of a contract interpretation involving a medically reviewable fact. So I think, at least of all the examples that occur to me as I stand here, those cases would all end up in State court.

As the Senator and I have spoken about on a number of occasions, he has a concern—and I understand it—about the possibility of there being some confusion about which cases go to State court and which cases go to Federal court. We think we have defined that fairly well in our bill.

I might add, in response to the Senator's question, that there is a principle involved in this which we have not discussed, which is that physicians, hospitals, and health care providers believe—and I agree with them—if an HMO is going to overrule their decision and engage in the practice of medicine, they ought to be treated the same way they are treated.

As the Senator knows, their cases are normally handled in State courts. So I think conceptually we start with the principle that HMOs should be treated the same as other health care providers when they make medical decisions.

No. 2, I say to my colleague that what we are doing is taking a Federal protection curtain that was unintended for HMOs when it was passed—because they basically did not exist—and lifting it. The effect of lifting it is they become subject to State court law.

So I think it is consistent in that respect. As the Senator and I have talked about before, it is also consistent with the fundamental concept that HMOs, if they are going to engage in the practice of medicine, ought to be treated as other health care providers.

I yield back to my colleague.

Mr. SPECTER. Madam President, I agree completely with my colleague from North Carolina that when HMOs engage in the practice of medicine, they ought to be treated like physicians.

But coming back to the distinction in the Edwards bill, which does have a provision on coverage as distinguished from medically reviewable decisions, there are two thoughts which occur to me. You have a whole body of case law—dozens of cases—which have wrestled with factual situations on coverage, whether a plan covered the specific item: The infant in the hospital for 24 hours; or the woman who was suicidal, whether the plan covered further hospitalization for her. And then those cases also involve counts on medical malpractice, on ''quality.''

So it seems to me it is very hard for my colleague from North Carolina to argue that it is not a commonplace occurrence to have specific cases arise where under his bill they would go to different courts. And then the express language of the Edwards bill has a delineation between medically reviewable decisions on malpractice and a category—''whether an item or service is covered under the terms and conditions of the plan or coverage.''

So I would direct perhaps only two more questions to my colleague from North Carolina—and I say perhaps.

The first question is—and I address this question through the Chair—isn't it conclusive where the Edwards bill has language which distinguishes ''whether an item or service is covered under the terms and conditions of the plan or coverage,'' as distinguished from medically reviewable decisions, that the Edwards bill contemplates these two categories, which under the Edwards bill are going to go to two different courts?

Mr. EDWARDS. Again, if I correctly understand the Senator's question——

Mr. SPECTER. I can understand the difficulty, Madam President, when people are whispering to him all the time. That is why I keep my people off the floor.

Mr. EDWARDS. I am trying very hard to listen to the Senator.

Madam President, if I may respond to the Senator's question, the answer to the question is: I really think there is a fundamental question that the Senator and I may have some disagreement about, which is contract interpretations that involve medically reviewable facts under our legislation go to State court. I believe that all of the examples the Senator has mentioned and all the examples I can think of would fall in that category.

Specifically as related to his concern about the possibility of there being two separate courts with jurisdiction, I think, in fact, that is not only highly unlikely but I can't think of a fact situation, as I stand here now, that would meet that criteria.

What we have done is to have a principle, and we have designed this bill around that principle. The Senator knows very well that this is the principle that was discussed in the Pegram case, a U.S. Supreme Court case, principle supported by the State attorneys general, the American Bar Association, this separation. It is a concept that makes sense in this context.

No legislation is perfect. We certainly can't eliminate the possibility that there may be in a hypothetical case some joint jurisdiction, but I can't think of such an example.

Mr. SPECTER. Madam President, I will direct this question to my colleague from North Carolina: How do you account for the many, many cases which have been litigated distinguishing between contract coverage, where really the language in the Edwards bill ''whether an item for service is covered under the terms and conditions of the plan,'' and a medically reviewable decision, where so many courts on so many cases labored with those distinctions, if, in fact, there aren't many cases where they are going to end up in different courts under the Edwards bill?

Mr. EDWARDS. Madam President, if I may respond to the Senator's question briefly, I believe it is because we have created a presumption that if the contract interpretation involves a medically reviewable fact, which is going to be the vast majority of cases—all the cases I can think of, as I stand here—those cases go to State court.

Those are the kinds of cases to which I believe the Senator is referring. I don't think the problem the Senator is addressing is one that is likely to occur in real life. We have specifically dealt with the issue of when there is a question, if it involves a medically reviewable fact, those cases go to State court.

Mr. SPECTER. Madam President, if it is unlikely, even with the brilliance and conceptual imagination of the Senator from North Carolina—he can't think of one—to occur in real life, why put this jurisdictional provision in the bill?

Mr. EDWARDS. Because there are two separate categories, if I may answer the Senator's question. There are two potential causes of action. If it involves any issue relating to medical care, specific medical fact, those cases go to State court. We treat the HMOs just as the doctor because they are engaging in the practice of medicine. If, on the other hand, the issue is one of were they covered for 60 days as the contract provided, do they meet some other specific contractual requirement, those are purely contractual issues that have been decided in Federal court for many years under ERISA. So we left those cases where they have traditionally been decided, which I think is the appropriate place to leave them.

Mr. SPECTER. Madam President, if you do have those contract decisions, isn't it entirely possible that there may be a factual situation arise where there is a matter of malpractice or a medically reviewable decision involved in the same occurrence?

Mr. EDWARDS. I would answer my colleague's question exactly the way I have before, which is, absent a presumption in our bill that if there is an involvement of a medically reviewable fact, I think the Senator's concern would be one that I would share. But we have dealt with that issue by specifically saying where the contract interpretation involves a medically reviewable fact, those cases go to State court. Those, in my experience and in my judgment, I believe will be the same cases that the Senator is describing as cases, I think he used the term, of medical malpractice.

Mr. SPECTER. Madam President, as they say in Oklahoma, we have gone about as far as we can go on this colloquy. I would advise the managers of the bill that I will be prepared to conclude my argument by 6:45.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. Madam President, I ask unanimous consent that if the other side does not require any additional debate, we begin the votes on the three pending amendments, which would be, in order, the Snowe amendment, the Enzi amendment, and the Specter amendment, beginning at 6:45.

The PRESIDING OFFICER. Is there objection?

Mr. REID. Madam President, reserving the right to object, we need Senator SNOWE to have 10 minutes, and she needs to offer a modification.

Mr. GREGG. We also need to have 2 minutes on Senator ENZI's amendment prior to his vote. So we would have 10 minutes prior to the Snowe amendment and 2 minutes prior to the Enzi amendment. And Senator SNOWE would have the right to modify her amendment.

Mr. REID. I accept that as a unanimous consent agreement in line with what we previously offered except for the time.

Mr. GREGG. I would have to add that it is my understanding Senator ENZI may divide the question on his amendment. That is his right, as I understand it; is that correct?

The PRESIDING OFFICER. The Senator is correct.

Mr. REID. If the Senator desires to divide his amendment, he may do so.

The PRESIDING OFFICER. Does the Senator wish the 10 minutes dedicated to Senator SNOWE to start at 6:45 or to begin now?

Mr. GREGG. It should begin prior to the vote.

Mr. REID. We are going to vote on the Specter amendment at 6:45.

Mr. GREGG. We are going to vote on the Specter amendment.

Mr. REID. At 6:45.

Mr. GREGG. We are going to vote on Snowe and then Enzi and then Specter.

Mr. REID. We do need Senator SNOWE here.

Mr. GREGG. She will be here. So 10 minutes on the Snowe amendment would begin at 6:45.

Mr. REID. Or when she arrives.

Mr. GREGG. Or when she arrives. And the votes would begin thereafter.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Madam President, these are on or in relation to the amendments as per the previous oral agreement?

Mr. GREGG. Right.

Mr. REID. I thank the Chair. The Senator from Pennsylvania has the floor.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. Madam President, I believe the colloquies with the Senator from Massachusetts and the Senator from North Carolina have made my point. That point is that there is jurisdiction created under the McCain-Edwards-Kennedy bill in two courts. There really is no doubt about that because section 302 provides for the availability of Federal civil remedies, and that covers whether an item of service is covered under the terms and plans and conditions, and later there are medically reviewable decisions in State courts.

Although there can be an inconclusive colloquy, as there is no confession or admission on the floor of the U.S. Senate, I think it is pretty plain that there are cases—and I have cited a whole series of specific cases in my presentation, Bauman, Pryzbowski, Lazorko, and Corcoran—where you had factual situations where you have an interpretation of a plan which would come under Federal jurisdiction—such as the mother's stay covered for more than 24 hours, the suicidal woman's coverage extended for hospitalization under that circumstance—then a combination of failure to have a plan coverage and also medical malpractice. And you have both claims brought.

And under the McCain-Kennedy-Edwards bill, it is plain that those two claims would be brought in separate courts beyond any question. It is not a matter of what the distinguished Senator can imagine. You have case after case which have had these interpretations, contract interpretation and ''quantity of care,'' and that goes to the Federal court. And then you have ''quality of care,'' and that goes to the State court.

I am not unaware of the realities of votes in this Chamber where a coalition has been formed, and there is a mindset. But I do hope that the managers of this bill will revisit this situation after this vote and when the bill goes to conference because having both these courts available is going to double the burden on plaintiffs who are injured—to make a contract interpretation claim in the Federal court and to go to the State court to make a medical malpractice claim—and it is going to require double expenses by the HMO, by the doctors, and by the hospitals—although you might have the doctors and hospitals eliminated from the Federal litigation, but the HMOs will certainly be there; and that is highly undesirable.

I have a grave concern about the speed of passage of this bill. Now, it is true we have been considering the Patients' Bill of Rights for a long time—many years. Too long. But this bill has come to the floor without the benefit of committee action, without the benefit of a markup; and what there has been is sort of a moving target markup of this bill on the floor by the committee of the whole, as we have gone through many amendments. But it simply cannot be denied that there are two sections of this bill, one conferring Federal jurisdiction and one conferring State jurisdiction, and the same factual situation would raise questions under both court systems, and this bill would require litigation in two courts.

That is very wasteful and very confusing. To call it a procedural quagmire is not an overstatement. The answer is fundamental, and that is to provide for exclusive Federal court jurisdiction, which I have in this legislation. You might argue that it could go to the State court and that would be an improvement rather than have both State and Federal courts. But it is very hard to move exclusively to the State courts where you have the long body of law built up under ERISA as to what is a plan's coverage. So given the fact that you are going to inevitably end up in the Federal court, the Federal court ought to be exclusive jurisdiction. And as the amendment provides, the damages will be determined by State law, no new Federal caps, but whatever State caps there were would be in effect.

I see my colleague from Illinois on the floor. He commented to me that he agreed with the provision that there ought to be unitary jurisdiction, but thought it ought to be in the State court. I will yield to the Senator from Illinois if he cares to use the limited time remaining.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. FITZGERALD. Madam President, I did want to, in part, agree with my colleague from Pennsylvania. I think he has identified an important problem that exists in the underlying bill. I have long favored creating liability for HMOs that harm someone because of their negligence. Right now, HMOs are protected. They are immune from liability, and that is a protection that almost no other individual or corporation has in this country, and I don't think it is defensible.

For the last 2 years, I have been voting regularly to make HMOs liable where they have been negligent. But I do think we have a problem in this bill in that we create State court tort liability by repealing the ERISA immunity in one part of the bill. That is on page 157, I believe. But then, at the same time, we create also tort liability, as well as more contract liability, and there already is contract liability under ERISA in Federal court.

The problem I see is that there are tort causes of action authorized in this

bill both in State court and in Federal court. I have always thought the playing field was tilted in favor of HMOs, and that playing field needs to be leveled. But I am concerned now that if this effect in the underlying bill is not remedied, the playing field will be tilted in the opposite direction.

The PRESIDING OFFICER. The hour of 6:45 having arrived, under the previous order, the Senator from Maine is to be recognized.

AMENDMENT NO. 834, AS MODIFIED

Ms. SNOWE. Madam President, I ask unanimous consent to modify the amendment that has been offered by Senator DEWINE, Senator LINCOLN, and Senator NELSON and send a modification to the desk.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered. The amendment is so modified.

The amendment (No. 834), as modified, is as follows:

(Purpose: To make technical corrections concerning the application of Federal causes of action to certain plans)

On page 2 of the amendment, between lines 9 and 10, insert the following:

''On page 144, lines 7 and 8, strike 'or under part 6 or 7'.''.

On page 3 of the amendment, strike line 14 and all that follows through line 21 and insert the following:

''(ii) DEFINITION.—A group health plan described in this clause is—

''(I) a group health plan that is self-insured and self administered by an employer (including an employee of such an employer acting within the scope of employment); or

''(II) a multiemployer plan as defined in section 3(37)(A) (including an employee of a contributing employer or of the plan, or a fiduciary of the plan, acting within the scope of employment or fiduciary responsibility) that is self-insured and self-administered.

On page 11 of the amendment, line 16, insert after the period the following: ''The provisions of this paragraph shall not apply in the case of a designated decisionmaker that is a group health plan, plan sponsor, or health insurance issuer and that is regulated under Federal law or a State financial solvency law.''.

Ms. SNOWE. Madam President, it is modified in the following way. First of all, the question was raised about the original intent of the amendment in regard to the self-insured, self-administered plans. Specifically, with regard to contractual dispute, it will only exempt from liability employer and union plans that are self-insured and self-regulated, again applying symmetry to all of the plans regarding self-insured and self-administered, so we do not make any exceptions. So we address that by modifying it to ensure that both employer and union plans are consistent with the legislation.

Secondly, because insurance plans are already regulated at State and Federal level with regard to assets and other issues, we assure that these regulated plans are not subject to a new Federal solvency plan to qualify as a designated decisionmaker. As a result, the solvency standard in this amendment will appropriately apply to non-health insurance designated decisionmakers.

Finally, we also make a technical correction in the legislation to ensure that the causes of action are not inadvertently opened to other statutes that are already a matter of law. This change reflects the intent of our amendment to prevent the filing of lawsuits in a broader, more undefined number of issues.

I urge adoption of the modification as well as the underlying amendment.

Again, I remind my colleagues that this was an effort to address many of the legitimate issues that were raised regarding employer liability. It was a consensus that was drafted along with my colleague from Ohio, Senator DEWINE, Senator LINCOLN, and Senator NELSON. I also thank Senator MCCAIN, Senator KENNEDY, Senator EDWARDS, as well as Senator GREGG and Senator FRIST, for working together to make this amendment possible. We thought it essential that we develop precise and clear guidelines in terms of how we establish employer liability but at the same time protecting patients' rights with their ability to seek legal redress when there is inappropriate care or denial of care.

We think we have developed and crafted the amendment in a way that creates the bright line and the firewall so that we do provide the necessary protection to employers, so that we limit and, in fact, in most instances I think prevent any exposure to liability. They can confer that liability and risk to the designated decisionmakers and therefore they will have that kind of liability protection, and patients will have their ability to be able to sue in those instances where they have been denied care or there has been wrongful injury, personal injury, or even death.

I think it strikes the right balance. The consensus represents the optimum approach to providing the kind of basis for removing an employer's exposure to litigation when they are not directly participating in medical decisions.

We hope this will satisfy the concerns that have been raised by the original legislation. We think we crafted the best approach, borrowing both from the McCain-Edwards-McCain legislation as well as the Breaux-Frist-Jeffords approach.

Again, I urge adoption of this amendment, as modified, and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

Mr. BAUCUS. Mr. President, I am proud to cosponsor amendment No. 834 with Senator SNOWE and my other colleagues. It addresses an issue important to all of us here—protecting employers from undue liability. This amendment clarifies any confusion about who is responsible for medical decision-making.

Under this amendment, employers who generally do not make medical decisions anyway—will be able to name a designated decision maker. If they contract with an insurance company, that company is automatically given the status of designated decision maker. The employer doesn't have to take any further action.

Once designated, this entity will have the authority to make medical decisions. And with this authority, the designated decision maker—not the employer—will have the responsibility for those decisions if they result in harm to the patient.

I believe this amendment serves as an important compromise. It enables employers to feel more comfortable offering their employees health benefits. And that's certainly something we want to encourage. But it also protects patients, and ensures that they receive all the protections provided under the Patients' Bill of Rights.

Mr. GREGG. Madam President, I understand the Parliamentarian has ruled that I have 5 minutes.

The PRESIDING OFFICER. There is 5 minutes in opposition.

Mr. GREGG. Madam President, unless somebody else is seeking that time, I will speak. I congratulate the Senator from Maine and the Senator from Ohio for adjusting this amendment. The changes they made in this amendment are very positive. The amendment moves in the right direction.

However, it must be made clear this amendment targets one narrow aspect of the concerns of this bill, and, in fact, there are still some issues in that aspect. Specifically, employers are going to have a very difficult problem figuring out whether they are a direct participant or whether they fall under the designated decisionmaker safe harbor.

There are issues within this narrow issue that are very significant.

The greater issues on the question of liability still remain very viable. It is of serious concern to those of us who look at this as extremely expensive legislation in the sense it will drive up health care costs and result in a lot of people losing their health insurance. Employers will drop the health insurance because of the liability aspects being thrown at employers in this bill and the costs employers simply are not going to bear. They will drop health insurance or reduce the quality of health insurance.

The estimates of CBO are in the range of 3.1 million, and OMB estimates are in the range of 1 million to 4 million people will lose health care. I think it will be literally tens of millions of people who will see the quality of their health care insurance degraded as their employers start to adjust.

As to this specific amendment, which is a narrow amendment, not an expansive amendment, the movement by the Senators from Maine and Ohio is to be congratulated. I thank them for it.

I yield back my time, and I yield the floor.

The PRESIDING OFFICER. Time is yielded back. The question is on agreeing to amendment No. 834, as modified. The yeas and nays have been ordered. The clerk will call the roll.

The bill clerk called the roll.

The result was announced—yeas 96, nays 4, as follows:

[Rollcall Vote No. 205 Leg.]

YEAS—96

| | | |
|---|---|---|
| Akaka | Domenici | Lott |
| Allard | Dorgan | Lugar |
| Allen | Durbin | McCain |
| Baucus | Edwards | McConnell |
| Bayh | Ensign | Mikulski |
| Bennett | Enzi | Miller |
| Biden | Feingold | Murkowski |
| Bingaman | Feinstein | Murray |
| Bond | Fitzgerald | Nelson (FL) |
| Boxer | Frist | Nelson (NE) |
| Breaux | Graham | Reed |
| Brownback | Gramm | Reid |
| Bunning | Gregg | Roberts |
| Burns | Hagel | Rockefeller |
| Byrd | Harkin | Santorum |
| Campbell | Hatch | Sarbanes |
| Cantwell | Helms | Schumer |
| Carnahan | Hutchinson | Sessions |
| Carper | Hutchison | Shelby |
| Chafee | Inhofe | Smith (NH) |
| Cleland | Inouye | Smith (OR) |
| Clinton | Jeffords | Snowe |
| Cochran | Johnson | Specter |
| Collins | Kennedy | Stabenow |
| Conrad | Kerry | Stevens |
| Corzine | Kohl | Thomas |
| Craig | Kyl | Thurmond |
| Crapo | Landrieu | Torricelli |
| Daschle | Leahy | Voinovich |
| Dayton | Levin | Warner |
| DeWine | Lieberman | Wellstone |
| Dodd | Lincoln | Wyden |

NAYS—4

| | |
|---|---|
| Grassley | Nickles |
| Hollings | Thompson |

The amendment (No. 834), as modified, was agreed to.

Mr. GREGG. Madam President, I move to reconsider the vote.

Mr. REID. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER (Ms. STABENOW). There are now 2 minutes equally divided on the Enzi amendment.

The Senator from Wyoming is recognized.

AMENDMENT NO. 840

Mr. ENZI. Madam President, under the amendment we just agreed to, we made some progress on handling liability. But there is a group of businesses that were left out. You will never hear me in this Chamber talk about big businesses. I always talk about the small ones. None of these is headquartered in Wyoming. But I am compelled to put in an amendment that will take care of a major problem which will take care of health care at the level they know it for 6 million people in the U.S. who work for the big, self-insured, self-administered companies, such as Hewlett-Packard, Caterpillar, Wal-Mart, and Pitney Bowes. None of those is in my State.

This provides an option to allow one of two ways of providing insurance to their people so individuals can get the right to sue if they want that right or they can stay with the plan which they presently get all the benefits from without any difficulty. This provides that option for them.

This is providing an option so that the company can avoid liability by providing a liability option for their people.

I ask for your support on this amendment to clear up what the people in your State need.

I also believe it is my right to divide the amendment on page 3, line 18.

The PRESIDING OFFICER. The amendment is so divided.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Madam President, let me just mention what this amendment is all about.

If an employer gives options to any employee, it can offer a program that is very inferior or it can provide a voucher that is inferior. You can't buy a good health insurance policy. If it offers those two options to any employee, and that employee denies it, then the employee who stays with that company is virtually excluded from bringing any action against the employer, no matter how involved the employer is in making medical decisions that can cause adverse reaction to that employee—either death or injury.

That is a lousy choice. This is an option many companies will take. It will be at the expense of the employees. They can get two inferior options. If they reject it and stay with the company, they are excluded from the benefits and the protections of this bill. It is going to open up a great exclusion for millions of hard-working Americans and their families. It should be rejected.

Mr. ENZI. Madam President, I ask for the yeas and nays.

The PRESIDING OFFICER. The yeas and nays have already been ordered.

The question occurs on division I.

The Senator from Nevada.

Mr. REID. Madam President, I move to table the whole amendment, and I ask for the yeas and nays.

The PRESIDING OFFICER. The yeas and nays have been ordered.

Mr. GREGG. Madam President, parliamentary inquiry: As I understand it, the question was divided. Is this a motion to table on the first part?

Mr. REID. Yes. That is true.

The PRESIDING OFFICER. That is correct.

Mr. GREGG. I thank the Chair.

The PRESIDING OFFICER. The question is on the motion to table division I.

The yeas and nays have been ordered, and the clerk will call the roll.

The assistant legislative clerk called the roll.

The result was announced—yeas 55, nays 45, as follows:

[Rollcall Vote No. 206 Leg.]

YEAS—55

| | | |
|---|---|---|
| Akaka | Biden | Breaux |
| Baucus | Bingaman | Byrd |
| Bayh | Boxer | Cantwell |
| Carnahan | Graham | Miller |
| Carper | Harkin | Murray |
| Chafee | Hollings | Nelson (FL) |
| Cleland | Inouye | Nelson (NE) |
| Clinton | Jeffords | Reed |
| Conrad | Johnson | Reid |
| Corzine | Kennedy | Rockefeller |
| Daschle | Kerry | Sarbanes |
| Dayton | Kohl | Schumer |
| Dodd | Landrieu | Specter |
| Dorgan | Leahy | Stabenow |
| Durbin | Levin | Torricelli |
| Edwards | Lieberman | Wellstone |
| Feingold | Lincoln | Wyden |
| Feinstein | McCain | |
| Fitzgerald | Mikulski | |

NAYS —- 45

| | | |
|---|---|---|
| Allard | Enzi | Murkowski |
| Allen | Frist | Nickles |
| Bennett | Gramm | Roberts |
| Bond | Grassley | Santorum |
| Brownback | Gregg | Sessions |
| Bunning | Hagel | Shelby |
| Burns | Hatch | Smith (NH) |
| Campbell | Helms | Smith (OR) |
| Cochran | Hutchinson | Snowe |
| Collins | Hutchison | Stevens |
| Craig | Inhofe | Thomas |
| Crapo | Kyl | Thompson |
| DeWine | Lott | Thurmond |
| Domenici | Lugar | Voinovich |
| Ensign | McConnell | Warner |

The motion was agreed to.

Mr. KENNEDY. Madam President, I move to reconsider the vote.

Mr. REID. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 840 DIVISION II WITHDRAWN

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. Madam President, I ask unanimous consent to withdraw division II of the amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The majority leader.

Mr. DASCHLE. Madam President, I announce to our colleagues that this will be the last vote of the evening. We will begin voting tomorrow morning at 9 o'clock on a series of votes on amendments that will be offered this evening. There is one more vote, but after that there will be no more notes.

AMENDMENT NO. 844

The PRESIDING OFFICER. There are 2 minutes now evenly divided on the Specter amendment.

Who yields time? Who seeks time?

The Senator from Pennsylvania.

Mr. SPECTER. Madam President, this amendment provides for exclusive jurisdiction in the Federal courts. Under the bill, there would be jurisdiction in the Federal courts for interpretation of the contract's coverage or what is referred to as ''quantity of medical care'', and jurisdiction in the State courts for what is called medical malpractice or ''quality of care.'' That means that for a plaintiff to bring a claim, they would have to go into two courts, enormously more expensive, and it would involve removal to the Federal courts and bouncing back and forth.

This amendment gives due deference to the States by using any State caps which are in effect and provides for State law on the computation of damages. With the life tenure of Federal

judges, the probability is high that the verdicts will be more realistic and more reasonable than we have seen in some of the State courts.

In the colloquies with the managers of the bill, it is obvious that there are many of these cases which involve both ''quantity'' and ''quality.'' During the floor presentation, I went over a number of cases where they bounced back and forth.

I urge adoption of this amendment.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. EDWARDS. Madam President, I have great respect for my colleague's expertise in this area. I appreciate very much his work. He and I have talked about this a number of times. The problem is that this amendment violates a fundamental principle on which we have based this entire legislation. That is, when HMOs and health insurance companies make medical decisions and overrule doctors, they should be treated exactly the same way doctors are treated. That is the reason our bill sends these cases to State court. It is the reason this is so critical for the AMA and medical groups all over this country.

They want the HMOs, if they are going to be in the business of overruling doctors' decisions, to be treated exactly the same as doctors and exactly the same as other health care providers.

For that reason, I reluctantly must oppose this amendment.

The PRESIDING OFFICER. The question is on agreeing to amendment No. 844.

Mr. SPECTER. Madam President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second. The clerk will call the roll.

The legislative clerk called the roll.

The result was announced—yeas 42, nays 58, as follows:

[Rollcall Vote No. 207 Leg.]

YEAS—42

| | | |
|---|---|---|
| Allard | Ensign | Murkowski |
| Allen | Frist | Nickles |
| Bennett | Gramm | Roberts |
| Bond | Grassley | Santorum |
| Brownback | Gregg | Sessions |
| Bunning | Hagel | Smith (NH) |
| Burns | Hatch | Smith (OR) |
| Campbell | Helms | Specter |
| Cochran | Hutchinson | Stevens |
| Collins | Inhofe | Thomas |
| Craig | Kyl | Thompson |
| Crapo | Lott | Thurmond |
| DeWine | Lugar | Voinovich |
| Domenici | McConnell | Warner |

NAYS—58

| | | |
|---|---|---|
| Akaka | Conrad | Hollings |
| Baucus | Corzine | Hutchison |
| Bayh | Daschle | Inouye |
| Biden | Dayton | Jeffords |
| Bingaman | Dodd | Johnson |
| Boxer | Dorgan | Kennedy |
| Breaux | Durbin | Kerry |
| Byrd | Edwards | Kohl |
| Cantwell | Enzi | Landrieu |
| Carnahan | Feingold | Leahy |
| Carper | Feinstein | Levin |
| Chafee | Fitzgerald | Lieberman |
| Cleland | Graham | Lincoln |
| Clinton | Harkin | McCain |
| Mikulski | Reid | Stabenow |
| Miller | Rockefeller | Torricelli |
| Murray | Sarbanes | Wellstone |
| Nelson (FL) | Schumer | Wyden |
| Nelson (NE) | Shelby | |
| Reed | Snowe | |

The amendment (No. 844) was rejected.

Mr. KENNEDY. I move to reconsider the vote.

Mr. SANTORUM. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

(Mr. DURBIN assumed the chair.)

Mr. KENNEDY. Mr. President, in just a few moments, I believe there will be a consent request by the minority floor leader to outline a series of amendments to consider and outline the order in which to take them up this evening, with disposition of those on the morrow.

It is not the intention, as we have gone through amendments, to second degree them. We are not prepared to say that until we have an opportunity to see those amendments. We are trying to work through the amendments at the present time. I hope perhaps we can get started on the discussion, and then in a few moments time when we have a chance to see each of the amendments, we can come back with the leadership proposal for an agreement on time and order this evening.

Mr. GREGG. Mr. President, we are ready to enter into an agreement relative to time and reserve the issue of second-degree amendments until the Democratic leader has had the opportunity to review the amendments. If we can get times locked in, that will be very helpful.

The PRESIDING OFFICER. The Senator from Virginia.

Mr. WARNER. Mr. President, parliamentary inquiry: Does the Senator from Virginia have an amendment pending at the desk?

The PRESIDING OFFICER. The Senator is correct.

AMENDMENT NO. 833, AS MODIFIED

Mr. WARNER. Mr. President, I send to the desk a modification to that amendment.

The PRESIDING OFFICER. The amendment is so modified.

The amendment (No. 833), as modified, is as follows:

On page 154, between lines 2 and 3, insert the following:

''(11) LIMITATION ON ATTORNEYS' FEES.—

''(A) IN GENERAL.—Notwithstanding any other provision of law, or any arrangement, agreement, or contract regarding an attorney's fee, the amount of an attorney's contingency fee allowable for a cause of action brought pursuant to this subsection shall not exceed ⅓ of the total amount of the plaintiff's recovery (not including the reimbursement of actual out-of-pocket expenses of the attorney).

''(B) DETERMINATION BY DISTRICT COURT.—The last Federal district court in which the action was pending upon the final disposition, including all appeals, of the action shall have jurisdiction to review the attorney's fee in accordance with subparagraph (C) to ensure that the fee is a reasonable one and may decrease the amount of the fee in accordance with subparagraph (C).

''(C) DETERMINATION OF REASONABLENESS OF FEE.—

''(i) INITIAL DETERMINATION OF LODESTAR ESTIMATE.—

''(I) IN GENERAL.—To determine whether the attorney's fee is a reasonable one, the court first shall, with respect to each attorney representing the plaintiff in the cause of action, multiply the number of hours determined under subclause (II) by the hourly rate determined under subclause (III).

''(II) NUMBER OF HOURS.—The court shall determine the number of hours reasonably expended by each such attorney.

''(III) HOURLY RATE.—The court shall determine a reasonable hourly rate for each such attorney, taking into consideration the actual fee that would be charged by each such attorney and what the court determines is the prevailing rate for other similarly situated attorneys.

''(ii) CONSIDERATION OF OTHER FACTORS.—A court may increase or decrease the product determined under clause (i) by taking into consideration any or all of the following factors:

''(I) The time and labor involved.

''(II) The novelty and difficulty of the questions involved.

''(III) The skill required to perform the legal service properly.

''(IV) The preclusion of other employment of the attorney due to the acceptance of the case.

''(V) The customary fee of the attorney.

''(VI) Whether the original fee arrangement is a fixed or contingent fee arrangement.

''(VII) The time limitations imposed by the attorney's client on the circumstances of the representation.

''(VIII) The amount of damages sought in the cause of action and the amount recovered.

''(IX) The experience, reputation, and ability of the attorney.

''(X) The undesirability of the case.

''(XI) The nature and length of the attorney's professional relationship with the client.

''(XII) The amounts recovered and attorneys' fees awarded in similar cases.

On page 170, between lines 21 and 22, insert the following:

''(9) LIMITATION ON ATTORNEYS' FEES.—

''(A) IN GENERAL.—Notwithstanding any other provision of law, or any arrangement, agreement, or contract regarding an attorney's fee, subject to subparagraphs (C) and (D), the amount of an attorney's contingency fee allowable for a cause of action brought under paragraph (1) shall not exceed ⅓ of the total amount of the plaintiff's recovery (not including the reimbursement of actual out-of-pocket expenses of the attorney).

''(B) DETERMINATION BY COURT.—The last court in which the action was pending upon the final disposition, including all appeals, of the action may review the attorney's fee to ensure that the fee is a reasonable one. In determining whether a fee is reasonable, the court may use the reasonableness factors set forth in section 502(n)(11)(C).

''(C) EQUITABLE DISCRETION.—A court in its discretion may decrease the amount of an attorney's fee determined under this paragraph as equity and the interests of justice may require.

''(D) NO PREEMPTION OF STRICTER STATE LAW.—Subparagraph (A) shall not apply with respect to a cause of action under paragraph (1) that is brought in a State that has a more restrictive law with respect to the amount of an attorney's contingency fee that may be incurred for the representation of a participant or beneficiary (or the estate of such participant or beneficiary) who brings such a

cause of action than the limitation on such fee under subparagraph (A).''

Mr. WARNER. I ask for the yeas and nays on the amendment, as modified.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The yeas and nays were ordered.

Mr. WARNER. Mr. President, it will be voted on whenever the managers desire.

The PRESIDING OFFICER. The Senator from New Hampshire.

Mr. GREGG. Mr. President, I ask unanimous consent that the following Members be recognized this evening: Senator DEWINE, 15 minutes, with the time equally divided, on class actions; Senator GRASSLEY for 30 minutes, with the time equally divided, on customs fees and other matters; Senator SANTORUM for 30 minutes, with the time equally divided, on the Born Alive Infant Protection Act; Senator BROWNBACK, 1 hour equally divided on a germline genetic amendment.

Mrs. BOXER. I ask my friend to repeat the Santorum amendment.

Mr. GREGG. Born Alive Infant Protection Act.

Mrs. BOXER. The Born Alive Equal Protection——

Mr. GREGG. Born Alive Infant Protection Act.

I presume it passed the House.

Mr. KENNEDY. On that there will be an objection to a time limit.

The PRESIDING OFFICER. Objection is heard.

Mr. GREGG. Why don't we begin with the DeWine amendment for 15 minutes, followed by the Grassley amendment for 30 minutes, and we will work on the rest.

The PRESIDING OFFICER. Is there objection?

Mr. KENNEDY. Reserving the right to object, and I do not intend to object, I appreciate what the Senator from New Hampshire is attempting to do. We have every inclination to support that proposal up to this point, but we reserve possible second-degree amendments and a tabling motion. We do not intend at this time to exercise those until we see the amendments, but we are going to operate on a good faith measure.

We are thankful for the leadership of the Senator from New Hampshire proceeding with those first two.

There are some others we might be able to get a time agreement on, as well, if the Senator wants to mention them.

Mr. GREGG. Of course, at this time we cannot proceed past the Santorum amendment until we get an agreement on that. At least I renew my request subject to the reservations of the Senator from Massachusetts, to which I have no objection.

The PRESIDING OFFICER. Is there objection to the unanimous consent request, as modified, for consideration of the amendments of Senators DEWINE and GRASSLEY?

Without objection, it is so ordered.

AMENDMENT NO. 842

(Purpose: To limit class actions to a single plan)

Mr. DEWINE. Mr. President, I have an amendment at the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Ohio [Mr. DEWINE] proposes an amendment numbered 842.

Mr. DEWINE. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

On page 171, between lines 14 and 15, insert the following:

**SEC. 303. LIMITATION ON CERTAIN CLASS ACTION LITIGATION.**

(a) ERISA.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 302, is further amended by adding at the end the following:

''(o) LIMITATION ON CLASS ACTION LITIGATION.—

''(1) IN GENERAL.—Any claim or cause of action that is maintained under this section in connection with a group health plan, or health insurance coverage issued in connection with a group health plan, as a class action, derivative action, or as an action on behalf of any group of 2 or more claimants, may be maintained only if the class, the derivative claimant, or the group of claimants is limited to the participants or beneficiaries of a group health plan established by only 1 plan sponsor. No action maintained by such class, such derivative claimant, or such group of claimants may be joined in the same proceeding with any action maintained by another class, derivative claimant, or group of claimants or consolidated for any purpose with any other proceeding. In this paragraph, the terms 'group health plan' and 'health insurance coverage' have the meanings given such terms in section 733.''.

''(2) EFFECTIVE DATE.—This subsection shall apply to all civil actions that are filed on or after January 1, 2002.''.

(b) RICO.—Section 1964(c) of title 18, United States Code, is amended—

(1) by inserting ''(1)'' after the subsection designation; and

(2) by adding at the end the following:

''(2)(A) No private action may be brought under this subsection, or alleging any violation of section 1962, where the action seeks relief concerning the manner in which any person has marketed, provided information concerning, established, administered, or otherwise operated a group health plan, or health insurance coverage in connection with a group health plan. Any such action shall only be brought under the Employee Retirement Income Security Act of 1974. In this paragraph, the terms 'group health plan' and 'health insurance issuer' shall have the meanings given such terms in section 733 of the Employee Retirement Income Security Act of 1974.

''(B) Subparagraph (A) shall apply to private civil actions that are filed on or after January 1, 2002.''.

Mr. DEWINE. Mr. President, I allowed the clerk to read because I wanted my colleagues to hear the essence of the amendment. It is a very simple amendment.

My amendment in a very rational way limits class action suits that could be filed as a result of this bill. The goal of the patient protection legislation under consideration, both the McCain-Kennedy bill and the Frist-Breaux-Jeffords bill, is, of course, to protect patients. We cannot be unmindful of the cost. Obviously, we have to be concerned about the cost, and we have to worry if any parts of this bill do in fact drive up the cost because ultimately this will impact how many employers do in fact offer health insurance. It is something with which we have to be concerned.

I believe my amendment offers a very simple way to curtail some of these increased costs. The problem is that the underlying bill will increase the cost of health care because the bill currently contains no language to limit the scope of class action lawsuits. This very possibility could lead to increases in the filing of onerous, burdensome, costly class action suits.

My amendment ensures that class action lawsuits are used in a very responsible way. I think my colleagues would agree that class actions can be very effective and can be efficient and can be a valuable tool to achieve justice.

As we also know, unfortunately, these suits sometimes are subject to abuse. That is why I believe we need to limit the target of these class actions. That is what our amendment does.

The reality is that our amendment is needed. Let me explain for a moment what our amendment does and then talk about what it does not do. Our amendment permits a class action to be filed with regard to the HMO, in regard to a plan, as long as we are only dealing with one company and the employees of that specific company. It says we cannot go beyond that.

The reality is that within every company there exists unique relationships between the company, the employees, and the health care plans. Because of that, it is impossible to compare different companies that happen to offer similar health care plans. The fact is that every company negotiates every contract differently. There may be similarities. Every situation is, obviously, different.

Now, at the same time, employees within the same company, with the same health care plan, who suffer the same way as a result of being denied entitled benefits, should have the right to band together to form a class and to file suit. That is why our amendment would recognize class actions within one company against one plan.

Our language essentially says this: One employer, one health care plan, one class action suit. It is that simple.

Here is how our amendment works if adopted. Suppose Ford Motor Company offers its employees the hypothetical Aetna Health Care Plan A. General Motors has this plan. Assume, also, that Chrysler has the same plan. Now, if employees at Ford have reason to band together in a class action against Aetna because they all believe they suffered harm because of the same denial in entitled benefits, they can go

ahead under our amendment and do that. Similarly, if employees at GM or Chrysler also believe they have suffered as a result of denial of the same benefits, GM and Chrysler employees can file their own class actions against Aetna. But employees at Ford, GM, and Chrysler can't join together in one suit against the health care provider.

This means class actions would be limited to employees within one company against one health care plan. Ultimately, we need this because abuse of class action lawsuits is not a road to assuring access to quality health care. If we want the bill before the Senate not to add unnecessary litigation and costs, I encourage my colleagues to adopt this amendment.

I reserve the remainder of my time.

I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is not a sufficient second.

Mr. MCCAIN. I repeat the request for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is not a sufficient second.

Mr. REID. If the Senator from Ohio wishes the yeas and nays, we would be happy to give those to him with the agreement that we will vote tomorrow.

Mr. DEWINE. I renew my request for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. Are Senators prepared to yield back time on the amendment?

Mr. DEWINE. I believe we have an understanding to reserve several minutes tomorrow morning for summation.

Mr. EDWARDS. Mr. President, there are a couple of issues—and I have just seen this amendment—a couple of issues raised immediately.

One, the entire Patients' Bill of Rights is about treating everybody the same. This, of course, carves out a special treatment for HMOs on the issue of accountability.

Second, this amendment makes a special exception under RICO for HMOs and under rules of procedure.

Third, it has been some time since I looked at the rules, I confess, but I seem to recall under class action law, rule 23 of the Federal Rules of Civil Procedure, there is a numerosity requirement, that you have to have a sufficient number of employees involved to satisfy the class action requirement, and I am not sure under the language the Senator has drafted that would be possible because I believe, if I understand the Senator's amendment correctly, he has limited it to one employer for purposes of class actions.

Mr. DEWINE. Obviously, the amendment does not change what the rules say as far as the number of people required for a class action. The Senator is correct; it does limit it to one company.

Mr. EDWARDS. I thank the Senator for his answer.

There is at least a serious question about that and we would need to go back and look. Under the Class Action Rules of Civil Procedure, it is my recollection there is a numerosity requirement that means a class has to be of sufficient size to be able to be certified as a class action, and I am not certain, if you limit the actions to one employer, that you don't effectively eliminate the possibility of a class action because that requirement cannot be met.

I confess to the Senator, that is from memory, and I will have to go back and look to be certain.

I have concerns about the fundamental question that the principle of this legislation is that we treat HMOs, for accountability purposes, as everyone else. And the notion of doing something specifically to protect them from class actions and to limit class actions and to limit the RICO statute is something that would violate that principle of which I would want my colleagues to be aware.

I yield the floor.

The PRESIDING OFFICER. Do the Senators yield back time?

Mr. DEWINE. I inquire, how much time remains?

The PRESIDING OFFICER. The Senator has 2 minutes remaining.

Mr. DEWINE. I will respond to my colleague and I appreciate his comments. He is closer to the courtroom in time than I am, and it has been many years since I have practiced law.

What this comes down to is that we are creating new opportunities for lawsuits, obviously, in this bill. What we are about is a balancing test, a balancing question. It is a matter of public policy. We have to decide. As we create new causes of action, new opportunities to file lawsuits, I think it is legitimate to look around and say: How expansive do we want to allow class actions to be under this new cause of action?

It seems to me language we have included, which is basically—basically, I say—what was in the Frist bill originally, is a rational way to do it. It doesn't ban class actions but basically says we are going to limit them. I think it is a balancing test and Members are going to have to make their own decision whether they think it is worth providing people with the opportunity to have nationwide class actions. Candidly, with the tremendous cost this is probably going to incur, that ultimately is going to be paid and ultimately going to drive up health care costs. I think Members have to make that decision.

I yield the remainder of my time.

The PRESIDING OFFICER. The Senator from Ohio yields the remainder of his time. The Senator from North Carolina has 10 minutes 48 second.

Mr. EDWARDS. If I may respond briefly to the comments of my colleague, the one issue he did not address, at least in his last answer—he may have discussed it earlier—is the issue of civil RICO. I believe I am correct in saying there are some State medical societies that have pending actions against them, civil RICO actions against HMOs, where they believe, obviously, the requirements of that statute have been met and there have been improper and illegal activities by the HMOs. Particularly as we go forward, if any State medical society believes those problems continue to exist, they may want to avail themselves of the civil RICO statute, a law that exists in part for that purpose.

Again, the trouble would be we are carving out special treatment for HMOs. Having said that, I do not disagree with the fundamental principle that is part of this process; it is public policymaking. We hope to balance the interests on both sides. I think that notion makes sense. My concern is we are carving out the HMOs from this particular statute when we are not carving anyone else out from this particular statute.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. DEWINE. Just to respond to my colleague—and I do appreciate his comments about RICO—again it is a balancing question each Member is going to have to decide.

Just to clarify things, I want to make it clear, the way this is drafted, we do not affect any pending issues, so those suits would not in any way be affected.

I yield the floor.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. EDWARDS. Mr. President, I yield my time?

Mr. DEWINE. I wonder if I may inquire whether or not there was a unanimous consent as far as the vote tomorrow morning at any time?

The PRESIDING OFFICER. There was no consent.

The Senator from Nevada.

Mr. REID. Senator DASCHLE has indicated we are going to come in at 9 o'clock in the morning and start voting. The first vote will be 15 minutes, and if there are other votes stacked, which I am confident there will be, there will be 10-minute votes on whatever is debated tonight. There is 10 minutes for the subsequent votes. There would be 4 minutes between each vote to debate.

Mr. DEWINE. Would that include the first vote?

Mr. REID. Yes.

Mr. DEWINE. So we would have in the morning then 4 minutes evenly divided prior to the first vote?

Mr. REID. That is right.

Mr. DEWINE. I yield the floor and thank my colleague from Nevada.

Mr. EDWARDS. We yield the remainder of our time.

The PRESIDING OFFICER. All time has been yielded back. Under the unanimous consent agreement, the Senator from Iowa, Mr. GRASSLEY, is recognized.

Mr. GRASSLEY. Mr. President, I yield myself such time as I might consume.

The PRESIDING OFFICER. Is the Senator sending an amendment to the desk?

AMENDMENT NO. 845

Mr. GRASSLEY. I send an amendment to the desk and ask for its immediate consideration.

The legislative clerk read as follows:

The Senator from Iowa [Mr. GRASSLEY] proposes an amendment numbered 845.

Mr. GRASSLEY. I ask unanimous consent the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To strike provisions relating to customs user fees and Medicare payment delay)

On page 179, strike lines 1 through 14.

Mr. GRASSLEY. Mr. President, I think three times during the debate on this bill I have been trying to make the point that bringing this bill to the floor usurped the consideration of the Senate Finance Committee of two provisions that are in the bill and another provision that ought to be in the bill that is not in the bill. My amendment today deals with striking sections 502 and 503. It is another way of my saying, as I tried to in an amendment 2 days ago on this legislation, to the Finance Committee, that people writing this legislation ought to keep their hands off subject matter that comes within the jurisdiction of the Senate Finance Committee. If people are writing a piece of legislation that comes out of Health, Education, Labor, they ought to find sources of revenue out of programs within their own jurisdiction to fund bills that they think up, rather than robbing another committee. That is basically what has happened.

I am opposed to both provisions on jurisdictional grounds because they are within the control of the Finance Committee, not the Health, Education, Labor, and Pensions Committee. But I also want to make it very clear it is not just jurisdictional, I also have concerns about what it does to policy, dealing with customs on the one hand and Medicare on the other hand. I want to review each of these in turn.

Section 502 of the bill extends the customs user fees from the year 2003 to 2011. This generates $7 billion over 8 years of the total revenue that it takes to fund this piece of legislation.

When Congress authorized these customs user fees, the avowed purpose was to underwrite the costs of customs commercial operations. But today in this bill, the fees are not being used for customs. They are being used to offset the cost of the Patients' Bill of Rights to the tune of $7 billion. I think this is unacceptable and violates the comity that one committee ought to have towards the other.

It also is unacceptable because when you have constituents who pay customs user fees for the purpose of having an efficient and effective operation of the Customs Service, so you can enter this country in an expeditious way, for those fees not to be used for what they were intended—for expedited entry to the country, to police illegal entry to the country, to police illegal drugs coming into the country, generally to make the customs agency's personnel more efficient and better able to do their job so the United States can be a sovereign nation protecting its borders the way it should—if these fees are extended, and I want to emphasize the word ''if,'' they should be extended in a thoughtful way, not as some budget trick to make the costs of this bill fit within the confines of the Federal budget.

I am not the only one who thinks so. I have received numerous letters from companies, from associations that are very concerned about this—Liz Claiborne, Inc., the National Association of Foreign Trade Zones, the Joint Industry Group, the National Retail Federation, the American Electronics Association, and also a memo from the U.S. Customs Service. They are all raising concerns because these are folks who pay this customs user fee, a fee that is meant to pay for bringing things into the country. They believe since the Customs Service is so outdated, so slow moving, not working in an expeditious way, this revenue ought to be used for the improvements in the customs operation that were anticipated when these fees were put in place. I ask unanimous consent these letters and memos be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

LIZ CLAIBORNE INC.,
*North Bergen, NJ, June 20, 2001.*

Hon. CHARLES E. GRASSLEY,
*U.S. Senate, Hart Senate Office Building, Washington, DC.*

DEAR SENATOR GRASSLEY. We write in opposition to a provision in the Patients' Bill of Rights (S. 1052) that would extend the merchandise processing fee, or ''mpf,'' for eight additional years. This is a trade-related measure, a user fee levied against importers like ourselves, that has no place in this legislation. We ask you to support efforts to delete the provision entirely.

First by way of background, the merchandise processing fee is an ad valorem fee levied against each import transaction, or ''entry.'' When it was passed 15 years ago, it was done so with the avowed purpose of underwriting the costs of commercial operations at the US Customs Service. In fact, however, it has never been used for that purpose. Instead, proceeds have been diverted to the general fund and act as a revenue source to balance the costs of other governmental programs. As of FY2001, the trade community has paid nearly $7.2 billion for merchandise processing, an amount far exceeding Customs' commercial operations budget.

In truth, the fee is really a tax on US imports and, from the beginning, we have objected strongly. It has been illegal under GATT and then World Trade Organization (WTO) rules, although the federal government has indulged in the fiction that it is a ''user fee.'' Now, under the terms of S. 1052, all pretense has been dropped and it is being offered as an offset to the costs of the Patients' Bill of Rights.

The fee is indeed due for renewal by 2003 and it is the trade communities' intention to seek its termination. While, before, the nation was experiencing a serious deficit, the reasons for its passage have since disappeared. Now, it is simply a tax on American citizens who buy imported products, whose price is inflated by the mpf. It is unconscionable to continue to tax Americans in this manner and we intend to seek repeal in the appropriate committee jurisdiction.

In the meantime, however, we ask that you assist us in removing the mpf funding from the Patients' Bill of Rights. The merchandise processing fee has no place in this debate. The fee will not be viewed on the merits in these proceedings, but is instead being used—cynically—as a ''pay-for'' a totally unrelated program.

Sincerely,

FRANK KELLY,
*Vice President, International Trade Compliance and Government Affairs.*

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NATIONAL ASSOCIATION OF FOREIGN-TRADE ZONES,
*Washington, DC, June 15, 2001.*

Hon. CHARLES GRASSLEY,
*Hart Senate Office Building, Washington, DC.*

DEAR SENATOR GRASSLEY. The National Association of Foreign-Trade Zones (NAFTZ) has learned that S. 872, Sec. 602 the ''Bipartisan Patient Protection Act'' provides for the extension of the Merchandise Processing Fee (MPF) through 2011. Congress established the fee to offset the cost of the commercial operations of the U.S. Customs Service. Not only does the proposed legislation continue the practice of allocating the MPF to the general fund of the U.S. Treasury with no relationship to the purpose of the fee, it completely eliminates the relationship of the fee to the Customs Service. We have serious reservations as to whether this is permissible through the General Agreement on Tariffs and Trade, and the World Trade Organization.

The NAFTZ is not opposed to the imposition of a fee for services rendered. We do believe, however, that any such fee must correlate to a discernible cost associated with the service provided. We are concerned that at a time when Congress is struggling to find the necessary funding to cover the cost of the modernization of the Service, that funds already designated by Congress for that purpose are being diverted.

Since the purpose of the MPF, as established by Congress, is to fund the commercial operations of the U.S. Customs Service, we are strongly opposed to any extension of the MPF without designating the revenue to that intended purpose and we respectfully request that you drop the merchandise processing fee extension from S. 872.

Thank you for your attention and consideration of our views. If you have any questions, please feel free to contact me.

Sincerely,

RANDY P. CAMPBELL,
*Executive Director.*

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JOINT INDUSTRY GROUP,
*June 20, 2001, Washington, DC.*

Hon. JOHN MCCAIN,
*U.S. Senate, Russell Senate Office Building, Washington, DC.*

DEAR SENATOR MCCAIN. The Joint Industry Group (JIG) expresses its opposition to a provision in the Bipartisan Patient Protection Act (S. 1052) that would automatically extend the U.S. Customs user fee from 2003 to 2011 (Sec. 502). This 8-year extension would remove any near-term opportunity to debate whether the fee should be continued or

whether an extension could be earmarked specifically for modernizing U.S. Customs operations.

JIG is a coalition of more than 160 companies, trade associations, professionals and businesses actively involved in international trade. We both examine and reflect the concerns of the business community relative to current and proposed international trade-related policies, actions, legislation, and regulations. We undertake to improve policies and procedures through dialogue with government agencies and the Congress. The Joint Industry Group represents over $350 billion in trade.

JIG members account for millions of dollars paid yearly in merchandise processing fees (MPF). Every year, Customs collects over $1 billion from companies importing goods into the United States. Additionally, companies are burdened by administrative costs associated with the fee, since Customs imposes complex reporting and accounting requirements on companies in the course of collecting fee payments. All this is occurring at a time when tariffs on products are declining and approaching zero.

If the Customs Service is to continue collecting this user fee it MUST directly fund improvements to Customs processing, specifically the Automated Commercial Environment (ACE) and other U.S. Customs initiatives that are greatly needed to improve the trade process. Improving Customs' ability to handle trade will become more critical as the amount of commerce entering the United States is expected to continue its double-digit rate of growth. While Section 502 of S. 1052 does not earmark user fees for health care purposes, it does use the fee as de facto justification for the revenue neutrality of the bill. JIG is greatly concerned that this approach will prevent user fees from being applied to the commercial operations of the U.S. Customs Service for which they are intended.

Use of the fee to offset the revenue impact of S. 1052 could also increase potential for a WTO dispute. In the late 1980's, a GATT panel found that the user fee was GATT-illegal because it was being collected in amounts exceeding the cost of Customs processing. While the U.S. addressed that problem by placing certain caps on the fee, it was clear from the panel finding that linkage of the fee to the cost of Customs commercial operations is of seminal importance to the question of GATT legality. If our trading partners believe Customs user fees are being used to fund health-care related goals, another GATT challenge is virtually certain to surface in the WTO.

For the reasons cited above, JIG would have no choice but to support such a challenge. It is clear that the proposed action in S. 1052 violates the WTO provisions to which the United States is a signatory.

We therefore urge that the user fee extender be removed from S. 1052. We need the opportunity to debate the merits of this fee when it comes up for renewal in 2003. If you have any questions about our views on this issue or wish to discuss the matter further, please contact Alan Atkinson at (202) 466–5490. Thank you for your consideration.

Sincerely,

RONALD SCHOOF,
*Chairman, Joint Industry Group.*

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NATIONAL RETAIL FEDERATION,
LIBERTY PLACE,
*Washington, DC, June 25, 2001.*

Hon. CHUCK GRASSLEY,
*Ranking Member, U.S. Senate Committee on Finance, Dirksen Bldg., Washington, DC.*

DEAR SENATOR GRASSLEY. The National Retail Federation (NRF) was surprised to learn that section 502 of the Bipartisan Patient Protection Act (S. 1052) contains an eight-year extension of the Customs Merchandise Processing Fee (MPF). The MPF is an administrative fee leveled on imports into the United States, through which U.S. retailers and other importers pay hundreds of millions of dollars every year.

NRF and the U.S. retail industry object most strongly to inclusion of this provision and, for the following reasons, we urge that the provision is stricken from the bill.

The Senate Finance Committee, which has jurisdiction over the MPF and other customs issues, was not consulted about this provision in S. 1052 and, has had no opportunity to consider the merits of extending the fee as currently structured.

The MPF was created to offset the administrative costs of the U.S. Customs Services' commercial operations, and any attempt to use it for other purposes, as this bill would do, is against the rules of the World Trade Organization.

The Finance and Ways and Means Committees have been working for some time with Customs and the importing community on renewing the MPF in a way that would ensure it be used for its proper and intended function—for commercial operations, including customs modernization funding.

It is unacceptable that extension of the MPF has been slipped into a health bill without the approval of the Committee of jurisdiction or the knowledge of those in the private sector that will be most directly affected as a result. At the same time, we are struggling to provide Customs Service with sufficient funds for a new computer system to allow Customs to modernize its operations and protect our nation's borders. If this provision in S. 1052 is allowed to stay, it will be impossible for the Senate Finance Committee to restructure the MPF program in the way it was intended—to finance the costs of Customs' operations. Accordingly, we ask for your help in insisting on the removal of this provision when S. 1052 comes to the full Senate for consideration.

The National Retail Federation (NRF) is the world's largest retail trade association with membership that comprises all retail formats and channels of distribution including department, specialty, discount, catalog, Internet and independent stores. NRF members represent an industry that encompasses more than 1.4 million U.S. retail establishments, employs more than 20 million people—about 1 in 5 American workers—and registered 2000 sales of $3.1 trillion. NRF's international members operate stores in more than 50 nations. In its role as the retail industry's umbrella group, NRF also represents 32 national and 50 state associations in the U.S. as well as 36 international associations representing retailers abroad.

Sincerely,

STEVE PFISTER,
*Senior Vice President, Government Relations.*

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AEA,
*Washington, DC, June 25, 2001.*

Hon. CHUCK GRASSLEY,
*Hart Senate Office Building,*
*Washington, DC.*

DEAR SENATOR GRASSLEY. AeA, the nation's largest high-tech trade association, is opposed to the provision (section 502) in the Bipartisan Patient Protection Act (S. 1052) that would extend the application of the U.S. Customs user fee from September 30, 2003, to September 30, 2011.

The U.S. importing community currently has full expectation that this import tax will expire as scheduled in 2003. As the leading U.S. importing sector, the U.S. high-tech sector would be particularly impacted by such a tax increase. Our member companies already pay tens of millions of dollars annually in customs user fees. In addition, there are additional administrative costs associated with the fee, since customs authorities impose complex reporting and accounting requirements on importers in the course of collecting the user fee payments. An unexpected, eight-year extension of the user fee, with its associated administrative costs, would be an unwelcome and unnecessary additional cost burden on our industry.

While section 502 of S. 1052 does not earmark user fees for health care purposes, it does use the fee as de facto justification for the revenue neutrality of the bill. We believe this provision introduces the potential that the U.S. Customs user fee will again be found contrary to U.S. international obligations under the WTO. In the late 1980's, a GATT panel found that the user fee was GATT-illegal because it was being collected in amounts exceeding the cost of customs services rendered. While the United States addressed that problem by placing certain caps on the fee, it was clear from the panel finding that linkage of the fee to the cost of customs commercial operations is of seminal importance to the question of GATT legality. If our trading partners believe customs user fees are being used to achieve healthcare related goals, another GATT challenge could well surface in the WTO.

For the reasons stated, AeA urges you to remove the customs user fee extender from S. 1052. This Patient Protection Act is an inappropriate forum for any consideration of extending the custom user fee. If you have any questions about our views on this issue or wish to discuss the matter further, please contact me at 202–682–4423.

Sincerely,

TIM BENNETT,
*AeA Senior Vice President International.*

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[From the Executive Office of the President, Office of Management and Budget, June 21, 2001]

STATEMENT OF ADMINISTRATION POLICY

(THIS STATEMENT HAS BEEN COORDINATED BY OMB WITH THE CONCERNED AGENCIES.)

S. 1052—Bipartisan Patient Protection Act. (Sens. MCCAIN (R) AZ, KENNEDY (D) MA, EDWARDS (D) NC) The President strongly supports passage of a patients' bill of rights this year and has been working with members of both parties since the first week of the Administration to forge a compromise. Congress has been divided on this issue for far too long at the expense of patients and their families. The President strongly urges Congress to pass a strong patients' bill of rights this year that provides meaningful protections for patients, not a windfall for trial lawyers or a threat to Americans' ability to obtain and afford quality health care. On February 7, 2001, the President transmitted to Congress his principles for a bipartisan patients' bill of rights and urged Congress to move quickly on this important issue.

The President's principles called for passage of a patients' bill of rights that ensures all Americans enjoy strong patient protections, including: access to emergency room and specialty care; direct access to obstetricians, gynecologists, and pediatricians; access to needed prescription drugs and approved clinical trials; access to health plan information; a prohibition of ''gag clauses''; consumer choice provisions; and continuity of care protections. The President also recognizes, however, that many States have passed strong patient protection laws already, some of which have been in force for over a decade. To the extent possible, a Federal patients' bill of rights should give deference to these effective State laws.

The President's principles emphasized the importance of providing patients who have

been denied medical care with the right to a fair, prompt, and independent medical review, which will ensure that disputes are resolved quickly and inexpensively and that patients receive the quality care they deserve.

The President stated that only after this independent review decision is rendered should we resort to the costlier, time-consuming remedy of litigation in Federal courts to ensure that health plans are held liable for wrongful decisions.

The President's principles also reminded Congress of the necessity of avoiding unnecessary and frivolous lawsuits, which will only serve to drive up costs and leave more individuals without insurance coverage. S. 1052 will significantly increase health insurance premiums and the number of uninsured. According to the Congressional Budget Office, health insurance premiums under S. 1052 as originally drafted would increase by over 4 percent. If the effects of litigation risk on the practice of medicine and of the reduced ability of health plans to negotiate lower rates were included, CBO's estimated cost impact could be much higher, by 4–5 percent or more. This is in addition to the estimated 10–12 percent premium increases employers are already facing in 2001. Further, leading economists have predicted that employers drop coverage for appropriately 500,000 individuals when health care premiums increase by 1 percent. According to these estimates, S. 1052 could cause at least 4–6 million Americans to lose health coverage provided by their employers.

The President is encouraged by efforts in the Senate, like those of Senators FRIST, BREAUX, and JEFFORDS, to develop a common sense compromise that forges a middle ground on this issue and meets the President's principles.

While the President strongly supports a comprehensive and enforceable patients' bill of rights and has been working with members of both parties to enact legislation this year, he believes that S. 1052 would encourage costly and unnecessary litigation that would seriously jeopardize the ability of many Americans to afford health care coverage.

The President objects to the liability provisions of S. 1052. The President will veto the bill unless significant changes are made to address his major concerns. In particular, the serious flaws in S. 1052 include:

—S. 1052 circumvents the independent medical review process in favor of litigation. The President believes that patients should be given care first—litigation should be the last resort. Patients should exhaust the medical review process first, allowing doctors, not trial lawyers, to make decisions about medical care.

—S. 1052 jeopardizes health care coverage for workers and their families by failing to avoid costly litigation. S. 1052 overturns more than 25 years of Federal law that provides uniformity and certainty for employers who voluntarily offer health care benefits for millions of Americans across the country. The liability provisions of S. 1052 would, for the first time, expose employers and unions to at least 50 different, inconsistent State-law standards. The result will inevitably be that employers and unions will be forced to pay for different benefits from State to State, even within a particular State, based on varying precedents set in State courts and leading to inconsistent standards of care for patients. Further, S. 1052 imposes no limitations on State court damages, and it is not clear whether existing State-law caps would apply to the broad, new causes of action in State courts that S. 1052 creates.

S. 1052 also would allow causes of action in Federal court for a violation of any duty under the plan, creating open-ended and unpredictable lawsuits against employers for administrative errors. These new federal claims do not have any limitations on the amount of noneconomic damages, creating virtually unrestrained damage awards that are limited only by an excessive $5 million cap on punitive damages.

Moreover, S. 1052 would subject employers and unions to frequent litigation in State and Federal court under a vague ''direct participation'' standard, which would require employers and unions to defend themselves in court in virtually every case against allegations that they ''directly participated'' in a denial of benefits decision. Because such determinations are inherently fact-specific, any such allegation will force a costly and time-consuming court process and result in varying State interpretations of ''direct participation,'' forcing employers to adhere to different standards in every State.

—S. 1052 fails to provide a fair and comprehensive remedy to all patients. The President believes the new Federal law should establish a comprehensive set of rights and remedies for patients. S. 1052 instead encourages costly litigation by providing no effective limitations on frivolous class action suits and allows trial lawyers to go on fishing expeditions to seek remedies under other Federal statutes.

—S. 1052 subjects physicians and all health care professionals to greater liability risk. S. 1052 would expand liability for physicians and all health care professionals in State courts well beyond traditional medical malpractice by permitting new, undefined causes of action in State courts for denials of medical benefits. This expanded litigation against physicians and all health professionals will create an opportunity to circumvent State medical malpractice caps that may not apply to these new causes of action.

—Extraneous User Fee Provision. The Administration objects to inclusion in S. 1052 to an extraneous revenue-raising provision (section 502), which extends for multiple years Customs charges on transportation, passengers, and merchandise arriving in the country.

PAY-AS-YOU-GO SCORING

S. 1052 would affect direct spending; therefore, it is subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990. OMB's preliminary scoring estimate of the bill is under development.

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U.S. CUSTOMS SERVICE,
*Washington, DC, June 20, 2001.*

Memorandum for James F. Sloan, Acting Under Secretary (Enforcement).
From: Acting Commissioner
Subject: Pay-go Offset for the Patient Bill of Rights

Congress will soon consider passage of the Patient Bill of Rights. The Customs Service offers no opinion of the legislation. However, we have concerns with the bill's potential impact on future Customs appropriations. Section 502 of the bill would extend our collection of COBRA fees from 2003 to 2011, but would use the revenue to offset the cost of implementing this new legislation. Although we support extending the collection of COBRA fees, any scoring of the COBRA extension which would limit, in any way, the ability to fund or offset Customs activities would likely cause a critical funding shortfall for the Customs Service.

Section 502 of the bill states: Section 13031(j)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(j)(3)) is amended by striking ''2003 and inserting 2011, except that the fees may not be charged under paragraphs (9) and (10) of such subsection after March 31, 2006''.

The COBRA fees collected by Customs are used both to reimburse Customs appropriation for certain costs, such as overtime compensation, and to offset a portion of the Customs Service Salaries and Expenses Appropriation (S&E). As an example, our FY 2001 collections will offset approximately $1 billion or almost 50 percent of Customs appropriation this year. Authorizing a COBRA extension to offset costs for something other than the Customs Service could negatively impact our available funding. Additionally, the Merchandise Processing Fee authorized in the COBRA is a fee that is paid by importers for the processing of merchandise by the Customs Service. Directing the funds collected from this fee for something other than Customs operations could pose GATT interpretation issues.

While Customs supports the extension of the COBRA fees, we also acknowledge that changes are warranted with the manner in which we collect those fees. We intend to review this issue in the near term.

Mr. GRASSLEY. I want to speak specifically to what one company wrote:

The merchandise processing fee has no place in this debate. The fee will not be viewed on the merits in this proceeding, but is instead being used—cynically—as a ''pay-for'' for a totally unrelated program.

Obviously, the totally unrelated program is the Patients' Bill of Rights that is before us.

Our experience today—in other words, how we handle this issue of customs user fees today—will only hurt us in our deliberation of what ought to be done to expedite and make more efficient entry into our country. It is going to hurt us when that policy debate comes up sometime down the road—weeks, months, but sometime. Customs modernization is a very important priority.

My point is that there are important Customs modernization issues that should no longer be ignored. Let's not have a rush to pay for this Patients' Bill of Rights today and blind us towards the real public policy questions we have on the Customs Service and their problems tomorrow.

Are you concerned about drugs at our borders? Are you concerned about illegal transshipment of textiles, import restrictions on steel and lumber, and backup of trucks at our borders? If you vote for extending fees, there will be no committee consideration if Customs is using the fees for these or other Congressional priorities.

I would like to tell you that extending these fees will definitely have an impact on what we are able to do or not to do about modernization of the Customs agency and its operations around the borders of our country, even in the interior of the country where we have Customs operations.

I would like to read what the acting Customs Commissioner had to say about this. He wrote on June 20, this year:

Any scoring which would limit in any way the ability to fund or offset Customs activities would likely cause—

And it is highlighted—

a critical funding shortfall for the Customs Service.

Experience a critical funding shortfall when you want to get in and out of Chicago with some Customs operations and people are complaining because it takes so long to get it done because of a shortage of personnel and not having the technical equipment that ought to be there to help efficient operation. Then you know that maybe you made the wrong decision when you took $7 billion out of Customs to do this.

Also, I have a statement, which was submitted for the RECORD, from the President himself, dated June 2001, clearly opposing section 502 of the bill.

I would like to raise one other issue, and that is it is not at all clear that using Customs user fees to offset revenue is consistent with the World Trade Organization rules.

Think about that. We are making a decision to take $7 billion out of Customs user fees under the jurisdiction of the Senate Finance Committee, and we may be doing this in a way that does not meet our obligation under the World Trade Organization. Under that organization, Customs fees are to be used as payments for Customs services, not as a source of general revenue to the Federal Government.

In a sense, as we would say to our constituents back home, you pay a gas tax, and we use the gas tax for transportation, to build highways. When people pay Customs fees, they pay those Customs fees for facilitating entry of product into the country and the policing of that entry of product into the country. A fee levied for a certain purpose ought to be used for that purpose or it might violate the WTO because it should not be a source of general revenue any more than taking money from the gas tax and putting it into the general fund of the United States.

Here is what the Customs Service writes on this issue.

> The merchandise processing fee is a fee that is paid by importers for the processing of merchandise by the Customs Service. Directing the funds collected from the fee for something other than Customs' operations could pose GATT interpretation issues.

While it is not clear that a WTO case would arise or that a challenge would be successful, it seems to me that this is a warning bell that should certainly be heard.

No Senator should vote against this motion to strike unless they are prepared to face the possibility of a WTO challenge and take responsibility accordingly.

We should strike this provision from the bill. Before blindly supporting section 502, we should have time to consider its broader implications.

I urge my colleagues to support this amendment to strike.

Turning to the other provision of their bill that my amendment strikes, section 503, that would delay payments to Medicare contractors by one day thereby shifting $235 million in Medicare part B spending from fiscal year 2002 to fiscal year 2003 is simply a budget gimmick.

I am troubled by this provision because it comes within the jurisdiction of the Senate Finance Committee and also because we are trying to work to make Medicare a better program, not do things to harm it.

First, I point out to my colleagues that, again, the Finance Committee has jurisdiction, not the Committee on Health, Education, Labor and Pensions. It is the Finance Committee that authorizes and overseas the Medicare Program and the Federal agency that runs it, now known as the Center for Medicare Services.

It is the Finance Committee and not the Health, Education, Labor, and Pensions Committee that is in the best position to know how changes in the Medicare Program, such as this one-day payment delay in section 503 of this bill that will affect our senior citizens, will affect our health care providers and will affect the integrity of the Medicare trust fund.

With all due respect, when it comes to Medicare and Medicaid and other Federal entitlement programs, it seems terribly ridiculous to ignore the committee that has the very expertise in these programs, meaning the Senate Finance Committee.

The second reason that I am proposing to strike the Medicare payment delay in section 503 of the bill is that the delay itself, which may not seem serious to some, could actually have consequences for Medicare contractors and providers.

Delaying payments by one day and moving them into the next fiscal year just to finance this bill is fuzzy math, to say the least. But it unfairly subjects the already fragile Medicare Program and its health care contractors to accounting disruptions and to administrative uncertainties.

Medicare providers already have it hard enough just dealing with the Medicare Program in the first place. They are overwhelmed by paperwork, confused by conflicting regulations, and frequently left hearing that ''the check is in the mail.''

Can you imagine the Federal Government saying ''the check is in the mail'' when it comes to timely payments of their reimbursements?

Subjecting those providers to any additional delay, even if just for a short period of time, is simply unfair. We need to make it easier for providers to do business with Medicare.

Think about it. No one wants to do business with late payers, and health care providers are no exception.

Think about it for a minute. No one wants to do business with late payers, and health care providers are no exception. We should not be giving Medicare an additional opportunity to delay for one minute—let alone a longer period of time—their obligations to promptly pay providers.

For the last 3 months, Senator BAUCUS and I have been working hard to develop a Medicare reform proposal that strengthens and improves the program by adding prescription drug coverage and making the entire benefit package more modern.

Part of this bipartisan effort also includes an initiative to make Medicare more responsive and accountable to both seniors and providers. We want to send a message to providers that they will be treated fairly and professionally by Medicare.

Unfortunately, the delay provision in section 503 does exactly the opposite. It sends an entirely wrong message and undercuts our bipartisan effort to make Medicare a better business partner for today's providers.

For these reasons, I cannot support the inclusion of section 503 in this bill. Neither 502 nor 503 belong in this bill. They are both outside the jurisdiction of the Health, Education, Labor Committee and a long way away from the subject of this debate, which is patients' rights. Both sections should be stricken from this bill entirely.

Consequently, I urge my colleagues to support my amendment.

The PRESIDING OFFICER. The time of the Senator has expired.

Who yields time in opposition?

The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I will take just a few moments of the Senate's time.

The fact is, this provision, as stated on page 179, does not even go into effect until the year 2003. There is plenty of time for the Finance Committee to work it out if this isn't a satisfactory way of dealing with this issue. It is basically a bookkeeping issue. There is a judgment that is made by CBO that the value of a wage package is ''X,'' and if you are going to guarantee additional kinds of benefits in terms of health care, then the wages are going to go down, which is going to mean less money in terms of Social Security.

This is actually a balance from the Budget Committee's point of view to make sure that the bookkeeping will be balanced.

Tomorrow, we will hear from the chairman of the Budget Committee who will describe this and, at the appropriate time, make the point of order.

I point out, though, it is my understanding that this has no impact or effect on the Customs Service. They will still receive the money. If they want to go through with their modernization, they will still be able to do that. But it basically ensures that this is going to conform to the budget consideration. That is the reason that this was put in there. There will be sufficient time for the Finance Committee to make any other kinds of adjustments and changes.

To make it very clear, the resources that are collected in this are not to pay for the bill. It is basically a bookkeeping offset to what will be anticipated to be the shortfall in terms of the payments under the CBO estimate of the wage package because of the enhanced value, which I think ought to

be encouraging for workers of their health benefits. So we will hear more from the Budget Committee tomorrow. At that time, the chairman of the Budget Committee will make a further comment, speaking for the Budget Committee. They are in support of our position.

Mr. GREGG. Is the Senator yielding back his time?

Mr. KENNEDY. I am glad to yield back the time.

The PRESIDING OFFICER. The Senator from Massachusetts yields back the remaining time on the Grassley amendment.

Mr. GRASSLEY. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. GREGG. I ask unanimous consent that this amendment and all amendments that have the yeas and nays ordered tonight be stacked for a vote tomorrow morning, with the appropriate time of 2 minutes to each side, or whatever is agreed to, before each amendment is voted on.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. GREGG. Mr. President, at this time I would like to outline the remainder of the evening, if acceptable to the parties, relative to our side, which would be that Senator SANTORUM would go next with his amendment. He would have 10 minutes; the Senator from California, Mrs. BOXER, would have 10 minutes. Then we would go to Senator NICKLES. He would have 10 minutes; and 10 minutes to whoever is in opposition. Senator BROWNBACK would come next. He would have an hour divided, as is traditional. And Senator ENSIGN would then follow with two amendments, the physician pro bono amendment and the genetic discrimination testing amendment.

I believe the Democratic membership has all these amendments. I would hope we could also agree there would be no second degrees.

Mr. KENNEDY. The Ensign amendment we have just received. I have no objection to the earlier request. I am sure we will agree with this, but we would like for that, as far as it being locked in in terms of no second-degree amendments, just to have an opportunity to——

Mr. GREGG. I would reserve my request on the second degrees relative to the Ensign amendments but ask unanimous consent that the unanimous consent agreement include that there be no second degrees on DeWine, Grassley, Nickles, Santorum, or Brownback.

The PRESIDING OFFICER. Is there objection?

The Chair hears none, and it is so ordered.

The Senator from Pennsylvania is recognized.

AMENDMENT NO. 814

Mr. SANTORUM. Mr. President, I have amendment No. 814 at the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Pennsylvania [Mr. SANTORUM], for himself, Mr. SMITH of New Hampshire, and Mr. DEWINE, proposes an amendment numbered 814.

Mr. SANTORUM. I ask unanimous consent reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To protect infants who are born alive)

On page 179, after line 14, add the following:

**SEC. ___. DEFINITION OF BORN-ALIVE INFANT.**

(a) IN GENERAL.—Chapter 1 of title 1, United States Code, is amended by adding at the end the following:

**''§ 8. 'Person', 'human being', 'child', and 'individual' as including born-alive infant**

''(a) In determining the meaning of any Act of Congress, or of any ruling, regulation, or interpretation of the various administrative bureaus and agencies of the United States, the words 'person', 'human being', 'child', and 'individual', shall include every infant member of the species homo sapiens who is born alive at any stage of development.

''(b) As used in this section, the term 'born alive', with respect to a member of the species homo sapiens, means the complete expulsion or extraction from his or her mother of that member, at any stage of development, who after such expulsion or extraction breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the umbilical cord has been cut, and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, caesarean section, or induced abortion.

''(c) Nothing in this section shall be construed to affirm, deny, expand, or contract any legal status or legal right applicable to any member of the species homo sapiens at any point prior to being born alive as defined in this section.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 1 of title 1, United States Code, is amended by adding at the end the following new item:

''8. 'Person', 'human being', 'child', and 'individual' as including born-alive infant.''.

The PRESIDING OFFICER. Under the unanimous consent agreement, the Senator from Pennsylvania is recognized for 10 minutes.

Mr. SANTORUM. Mr. President, this is an amendment that I think really goes to the heart of this bill: Patient protection. This bill is purported to deal with trying to take care of patients. What this amendment does is make sure that every living human being is protected by this act as well as all other acts of Congress.

This is a very simple amendment that says—I am quoting from the amendment—

In determining the meaning of any Act of Congress, or of any ruling, regulation, or interpretation of the various administrative bureaus and agencies of the United States, the words ''person'', ''human being'', ''child'', and ''individual'', shall include every infant member of the species homo sapiens who is born alive at any stage of development.

That is a rather simple amendment. Obviously, I think it is an amendment that should be broadly accepted.

The reason I offer this amendment is really twofold. No. 1 is the concern about how certain little children—little infants—are treated, particularly those who are born alive after an abortion, an abortion that was not successful in the sense that the child was not killed before the child was delivered outside of the mother's womb.

So what we want to do is make sure those children in particular, as well as others, are treated with the same dignity and are covered by the same laws as all other people in America.

There are, unfortunately, many disturbing examples of how these little children are not treated the same and not given the proper care and, frankly, the proper respect that is required under the laws that we have passed in this Congress.

I am going to use a couple of examples that were given by nurses in congressional testimony.

Last year, we had testimony from Allison Baker, who is a registered nurse, who witnessed three induced abortion survivor incidents. For one of them, she says:

I happened to walk into a ''soiled utility room'' and saw, lying on the metal counter, a fetus, naked, exposed and breathing, moving its arms and legs. The fetus was visibly alive, and was gasping for breath. I left to find the nurse who was caring for the patient and this fetus. When I asked her about the fetus, she said that she was so busy with the mother that she didn't have time to wrap and place the [baby] in the warmer, and she asked if I would do that for her. Later I found out that the fetus was 22 weeks old, and had undergone a therapeutic abortion because it had been diagnosed with Down's Syndrome. I did wrap the fetus and place him in a warmer and for 2½ hours he maintained a heartbeat, and then finally expired.

The second incident involved a 20-week-old fetus with spina bifida who lived for an hour and 40 minutes until she died.

She continued:

The third case occurred when a nurse with whom I was working was taking care of a mother waiting to deliver her 16 week Down's Syndrome fetus. Again, I walked into the soiled utility room and the fetus was fully exposed, lying on the baby scale. I went to find the nurse who was caring for this mother and fetus, and she asked if I could help her by measuring and weighing the fetus for the charting and death certificate. When I went back into the soiled utility room, the fetus was moving its arms and legs. I then listened for a heartbeat, and found that the fetus still was alive. I wrapped the fetus and in 45 minutes the fetus finally expired.

We have other stories, disturbing stories of cases where children were born alive and basically discarded as trash in soiled utility closets or laying on tables fully exposed at a very tender age.

This is a story from Jill Stanek, another registered nurse:

One night, a nursing co-worker was taking an aborted Down's Syndrome baby who was born alive to our Soiled Utility Room because his parents did not want to hold him, and she did not have time to hold him. I couldn't bear the thought of this suffering child lying alone in a Soiled Utility Room, so I cradled and rocked him for the 45 minutes that he lived. He was 21 to 22 weeks old, weighed about ½ pound, and was about 10 inches long. He was too weak to move and very much expending any energy he had to breathe.

This is the current problem, and this is the reason we are introducing this legislation. Frankly, I have concerns that this may be even more of a problem in the future based on court decisions. The court decision I refer to is the recent decision by the U.S. Supreme Court in the Nebraska partial-birth case. In that case, in a concurring opinion, two Justices said two things: One, Justice Stevens with Justice Ginsburg concurring, and the other, Justice Ginsburg with Justice Stevens concurring. I am going to quote two things that should send a chill down the spines of people here when it comes to what the future could have in store for us if we do not pass legislation such as this.

This is what Justice Stevens said in this decision:

The holding [of Roe]—that the word ''liberty'' in the 14th Amendment includes a woman's right to make this difficult and extremely personal decision—makes it impossible for me to understand how a State has any legitimate interest in requiring a doctor to follow any procedure other than the one he or she reasonably believes will best protect the woman in her exercise of this constitutional liberty.

For the notion that either of these two equally gruesome [abortion] procedures performed at this late stage of gestation is more akin to infanticide than the other, or that the State furthers any legitimate interest by banning one or not the other, is simply irrational.

What that says very clearly is, according to these two Justices, that any procedure that the doctor determines is in the best ''health interest of the mother'' can be used without question. So if the doctor believes the best way to safely perform this abortion is to deliver a live baby and then subsequently kill it because it is the safest way for the mother's health to have that done, under this rationale, under this reasoning, that would be legitimate. I think we have to make it very clear that that is not legitimate; that after delivering a baby, once the baby is outside the mother, it is no longer legitimate to consider that child just a piece of property to be disposed of, or massive cells to be disposed of when it is a living, breathing individual.

Justice Ginsburg's opinion says the following:

Such an obstacle [to abortion] exists if the State stops a woman from choosing the procedure her doctor ''reasonably believes will protect the woman in [the] exercise of [her] constitutional liberty.''

Again, it is an open door to whatever procedure the doctor wants to use, irrespective of the baby, which again leaves the door open certainly for the doctor to say that he or she reasonably believes that the mother's health will be served if the baby is delivered and then killed because that is the safest way. This was not the majority opinion, thankfully, of the Court, but it does show that there is a possibility, at least, out there for this kind of ruling within our court systems at the highest level, much less what some district or appellate court might do.

I think it is important for us to clearly draw the line, if that is called drawing the line, that once a child is born, it is no longer a health threat to the mother, and that we have a legitimate interest in protecting this child from being killed at that point or, shall we say, treat that child within the context of the law as we would treat any other child or any other person in America.

With that, I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time in opposition?

The Senator from California.

Mrs. BOXER. Mr. President, my colleague, in his discussion of this amendment, does attack the landmark case of Roe v. Wade which simply said, in the 1970s—and women have had the right since then—that in the early stages of a pregnancy, the government should play no role in the very personal, private, moral decision that a woman and her family and her doctor and her God would make without the interference of government. But his amendment certainly does not attack Roe in any way.

His amendment makes it very clear that nothing in this amendment gives any rights that are not yet afforded to a fetus. Therefore, I, as being a pro-choice Senator on this side, representing my colleagues here, have no problem whatsoever with this amendment. I feel good about that. I feel good that we can, in fact, vote for this together. It is very rare that we can.

Simply put, this amendment says it all in its purpose: ''To protect infants who are born alive.'' Of course, of course. My colleague goes on to say that simple statement, which is very important, is in fact, he said, the heart of this bill. I think the heart of this bill is even more than that. The heart of this bill is, yes, protecting infants; it is also protecting children, protecting teenagers, protecting people as they get older, until they are very old and very frail and are fighting for their life.

So this bill really should protect us all at every stage of our life, from the earliest days until the final days. I hope that my colleague will join with us in supporting this Patients' Bill of Rights because it does, in fact, protect all of us. And it will, in fact, give all of us at any stage, at any age, the quality health care that we need.

I can tell my friend, and I think I have mentioned it to him before and on the floor before, that I gave birth to two premature babies, one quite premature. And I can say right here and now that I will never, ever forget the experience of those doctors. This was a long time ago, I say to my friend; this was way back. Now my kids are taking care of me. And the doctor came in and grabbed my firstborn son and, before they could even take a cloth to clean him, ran him into the incubator where he had to stay for 1 month. Had I not had that kind of dedication from a pediatrician, that kind of concern, a hospital that knew at that time we didn't have the money to pay the $1,000 a day that it costs—now it is way more than that—I don't know if today I would have a beautiful healthy son who is married and the pride of our lives.

My daughter was also born premature, a similar circumstance, same thing:—dedicated people, dedicated hospital, quality care.

I join in voting for this amendment, with the understanding that all of us at every stage of our life deserve that kind of quality care. In other words, if my friend were to expand it and say every human being deserves quality health care, deserves, when they are in the hospital, to be protected, I would join with him as well. That is what I think the larger bill does do.

He believes it is necessary to single out infants. Fine. That is fine.

Again, I say to my friend in the chair that we will be voting for this amendment, I hope unanimously. If we have to have a recorded vote, that is fine. And we will state that we feel very strongly that every person deserves protection from this health care system and that this Patients' Bill of Rights should give us all the care that we deserve and all the care our families deserve, regardless of whether we are a helpless newborn baby or whether we are an elderly person who is fighting and struggling against illness.

If 100 people vote for this amendment, which I think will be the case, then 100 people should vote for the Patients' Bill of Rights because it will afford the families of those vulnerable infants and all of us the protections that we need against HMOs that oftentimes put dollar signs ahead of our vital signs. That is wrong to do. Some of these babies are born into families who don't have a lot of money, who don't have a lot of power, who are going against HMOs where the CEO makes hundreds of millions of dollars. But they say: Gee, we are not going to give that little baby the care he needs.

I had a case I talked about on the floor where a child was denied a medicine. She was 3 years old and had cancer. It was $54 for the medicine and the HMO denied that medicine. That child suffered so with nausea and all the rest, while the head of that HMO, because of a huge merger—and I asked my staff to check this because I could hardly believe it—made $800 million in the course of that merger. But they denied a drug to a little baby suffering from cancer—$54.

I heard my colleagues on the other side—some of them against this bill—

say: We can't legislate by anecdote. Well, I have to tell you, when you hear one story, and then another and another, from people you never heard of, and you hold hearings and the people come out and tell the stories, then we know there is a need to pass this Patients' Bill of Rights. So I would vote for this to protect the infants, and then I will vote to protect everyone in this country because everyone deserves protection from HMOs who put their bottom line ahead of people's health.

The PRESIDING OFFICER (Mrs. FEINSTEIN). The Senator from Massachusetts is recognized.

Mr. KENNEDY. Madam President, I am going to urge the Senate to accept the amendment tomorrow. I think we have had a good discussion about it. I hope that we will move ahead and accept it. I am prepared, when the Senators yield the time or use the time, to do that.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Madam President, I thank the Senator from California for her comments and support of this amendment.

I ask for the yeas and nays on the amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 846

Mr. NICKLES. Mr. President, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Oklahoma [Mr. NICKLES], for himself and Mr. ENSIGN, proposes an amendment numbered 846.

Mr. NICKLES. Madam President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To apply the bill to plans maintained pursuant to collective bargaining agreements beginning on the general effective date)

Beginning on page 173, strike line 19 and all that follows through line 14 on page 174, and insert the following:

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—The amendments made by sections 201(a), 301, 302, and 303 (and title I insofar as it relates to such sections) shall apply to group health plans maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers beginning on the general effective date.

Mr. NICKLES. Mr. President, I will be brief. I hope this amendment can be agreed to. In the underlying bill on page 173, it has ''effective dates'' for implementation of the legislation. The effective date for everybody, all plans in America, is by October 1, 2002. So that is when all the plans in America will have to comply with this bill. They will have to have the patient protections in line, the appeals process, the liability sections—all are mandated to be effective by October 1 next year. That is about 14 months from now.

If you continue reading on page 173, you find out that the plans that are covered by collective bargaining agreements are exempt. They are exempt from the legislation. It says they ''shall not apply to plan years beginning before the later of—(A) the date on which the last collective bargaining agreements relating to the plan terminates.''

Some of these plans may not terminate for months. Some may not terminate for years. As a matter of fact, looking at a couple of examples, one is the Plumbers and Pipefitters Union, with 2,200 employees, has a 128-month contract. It doesn't expire until 2010. The International Union of Electric Workers, with 1,800 employees, has a 148-month contract that doesn't expire until the year 2007. I could go on and on. There are lots of examples.

The point is that there are about 30 million lives that would be exempt from this bill for years. If we are going to make it apply to everybody else in the private sector, I think we should make it apply for collective bargaining plans as well.

There is also something else that is troubling to me. It says it would not apply until the plan terminates, and then the language says if they adopt these patient protections, that still doesn't count as a plan termination, a collective bargaining agreement termination. So, in effect, even though a plan adopts it, it hasn't terminated and, therefore, it is still not covered or enforced by the terms of this bill. I find that troubling. I also am troubled by the fact that when it says ''relating to the plan terminates,'' a lot of plans or contracts don't terminate. They are renegotiated. So they never get to termination. They are actually renegotiated and extended. That is well and good. That means there is peace and harmony and no labor shortages and so on.

My point is that it is very important for us not to be exempting 30 million workers who happen to be in collective bargaining agreements from the protections in these plans. If we are going to give these protections to 170 million workers in the private sector, in that 170 million are included 30 million who happen to be members of a collective bargaining agreement. They should have the patient protections that Congress is in the process of determining which are so vital for everybody else in the private sector. They should not be exempt because they happen to be members of the collective bargaining unit. We are asking every other plan in America to comply by October 1. Why would we not ask members of collective bargaining agreements to also comply? Why should we have them have different expiration dates, some of which might be 5, 10 years, or even longer?

Maybe this is an oversight, a mistake from a previous drafting; but, clearly, if these are such valued protections that we want to extend them to the private sector, we should certainly extend them to members of collective bargaining agreements as well.

I urge my colleagues to support this amendment.

The PRESIDING OFFICER. The Senator from Massachusetts is recognized.

Mr. KENNEDY. I yield myself 5 minutes.

Madam President, I direct my colleagues' attention to the lines 15 and 16 on page 173. They talk about ''for plan years.'' That is an art of words that applies to insurance companies, and it says, ''beginning on or after'' plan years. As we know, the insurance starts generally at the first of every year. So with regard to insurance companies, the Senator is completely wrong. This does not apply for insurance companies because there are existing contracts.

We have heard a great deal in this debate about the sanctity of the HMO contract and how we are not going to permit—in terms of the standards for the treatment of patients—they are going to be tied completely to the contract. I don't know how many hours I listened to that. Now we see that we are respecting the contract in insurance and we expect the same—to respect the contract in terms of collective bargaining. It is simple as that.

This is boilerplate, Madam President. We did this in the HIPAA program, and there was no row about it at that time. People understood. There was a normal transition, and we didn't have objections at that particular time. So that is what we have done here. There are existing contracts in insurance, and we take it to the next time when the insurance plans are going to be implemented. There are existing collective bargaining agreements. We are going to take it at the next time when they are going to be renegotiated because of the respect for the existing contracts.

So what is sauce for the goose should be sauce for the gander, Madam President, particularly when we are listening to so much about the importance of contracts and that we ought not interfere with them, even if it is going to be as a matter of medical necessity, and that we are going to be bound by them because they are so important and sacred. There is a sanctity of the contracts.

I listened to that for 5 hours, and now we find out in the final hours of this that, oh no, that is not true regarding collective bargaining. We are going to interfere with ongoing collective bargaining agreements. That just doesn't make sense. This is what we have done at other times. It says insurance, generally, at the start of a year—some are longer and they will be respected in that way just as we do regarding collective bargaining. I hope this amendment will not be accepted.

Mr. NICKLES. Madam President, I appreciate my colleague's statement,

but I totally disagree. Some of us have argued for contract sanctity, but we haven't been totally successful, I might add. Almost all those contracts would begin, if not by October 1, certainly by January 1 of the year 2003. So maybe there are a few more months. But under collective bargaining agreements, if you read the language on page 174, it is not until the contract or the agreement terminates. And then the second part of it says that even if they comply, it shall not count as a termination.

You could have collective bargaining agreements exempt under this provision indefinitely for 12 years. They may never terminate the agreement. They may continue rolling it over, so it is never terminated. It might be readjusted; it might be renegotiated; but it is never terminated. Are we going to take 30 million Americans and say: You are not covered by these patient protections?

Some of these contracts will last 10 years, 15 years. The average contract I was looking at had a schedule of 5 to 6 years. One I mentioned does not expire until the year 2010. If they renegotiate it between now and next year, the duration of the contract will be exempt. We are telling everybody else in the private sector: Get your act in order, and by the end of next year you have to have these new patient protections, oh, unless you are a member of a collective bargaining agreement.

This is not the only exemption we found. We did not cover Federal employees. Maybe I will have an amendment dealing with Federal employees. All these great patient protections do not apply to Federal employees. They do not apply to Medicare. They do not apply to Indians in our hospitals. They do not apply to veterans.

These are patient protections that are so important for the country, but we do not give them to publicly funded plans; we only do it for private sector plans.

What about unfunded mandates? What about union plans, collective bargaining? We leave them out. We leave out Government plans; we leave out union plans; but it is fine we are going to hit the private sector. Unions, this does not apply for the duration of your collective bargaining agreement, and if it does not terminate, you are never covered.

I think that is a serious mistake, so I urge my colleagues to support the amendment.

I thank my friend and colleague from Nevada for his support of the amendment as well.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Madam President, the Senator ought to read page 174 because this language is very clear, precise, and exact. It does not permit what he just said it permitted, and that is the rollovers. It just does not permit it.

The Senator can state it, and he can misrepresent it, which he just has, but it is not the fact. On line 5, it says: ''relating to the plan terminates,'' and that is when it ends. That is when it has to be implemented.

This idea that it can roll over and over, for 10, 15 years, is not what the legislation says. The fact is, with insurance, many start in January, many others start in July. We have tried to say when that contract plan year, which is a term of art that refers to when that insurance transitions, we will implement it at that time, and the same should be true with the collective bargaining agreements.

I would think the overwhelming majority of the workers and employers would be eager to get these protections. We are going to find out many will work out arrangements so they get the protections even earlier.

The PRESIDING OFFICER. Who yields time?

Mr. NICKLES. I yield to the Senator from Nevada such time as he desires.

The PRESIDING OFFICER. The Senator from Nevada is recognized.

Mr. ENSIGN. Madam President, I have a story that was told by the junior Senator from North Dakota on the Senate floor the other day. It is about a young man, Christopher Thomas Roe, who is from Nevada. He was attending Durango High School and was diagnosed with acute lymphocytic leukemia. As anybody who has had a child with that terrible disease knows, sometimes the treatments are not very successful.

During the course of his treatment, the doctors were recommending a certain type of experimental treatment, and as we have heard throughout this bill, sometimes that experimental treatment has to be had at a certain time of treatment, and waiting for its approval sometimes leads to that treatment not being able to be given to that patient. That is exactly what happened to Christopher Thomas Roe. He was not able to receive this type of a treatment in a timely manner.

His father is a school district employee in the State of Nevada. He is not a teacher, but he is an employee of the school district. There is an employee trust fund that has been set up to provide health insurance to school district employees. Based on our discussions with the Department of Labor, this trust fund, because of the way it was set up, would not be covered under the provisions of this bill.

Similarly, the 30 million people Senator NICKLES is talking about who deal with collective bargaining agreements are not covered adequately under this bill. If we are going to say to other people that they deserve these rights, we believe that people who are in unions deserve the same patient protections.

These patient protections right now do not just deal with lawsuits, they deal with provisions that everybody agrees with in the bill: The right of a woman to choose an OB/GYN as her primary doctor; the right of a family to say their children's primary care doctor is a pediatrician; the right to a reasonable layman's interpretation of whether emergency room care should be paid for when they have an emergency.

These patient protections we believe are very important to give not only to the 170 million people who are covered by the underlying bill, but also those who are covered in collective bargaining agreements.

If there is tweaking of the language that needs to happen with this amendment, then let's tweak the language. The bottom line is this is not an anti-union agreement. This amendment says we want union workers to have the same rights as other people.

I would think the other side of the aisle, who are generally in favor of union workers, would be on our side on this amendment. If the other side thinks this amendment needs a little tweaking, maybe we can do that, but right now as we read the bill, as we have had some of the legal experts look at the bill, collective bargaining agreements would supersede and not allow union workers who are covered under those collective bargaining agreements to be covered under this Patients' Bill of Rights.

I urge our colleagues to work with us and to make sure those union workers get the same protections as other people in America are going to receive.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Madam President, how much time do I have?

The PRESIDING OFFICER. Six minutes.

Mr. KENNEDY. I did not understand, did the Senator say that public employees were not covered? Does he understand that to be the case?

Mr. NICKLES. The Senator is correct. Federal employees are not covered by the underlying McCain-Kennedy bill.

Mr. KENNEDY. I understand he was talking about teachers in Nevada; public employees is the example he gave. I find this enormously interesting because both Senators voted for the Collins amendment that excluded 139 million Americans. They only included 56 million. They were going to have the protections. The others were going to be dependent upon whether the States actually moved ahead and passed the various protections.

One of the groups that was left out of the Collins amendment was public employees, such as firefighters, schoolteachers, and others. We resisted that. No one has fought harder to make sure we are going to have comprehensive coverage since day 1 of this program. Now we are being flyspecked because somehow there are some who, under certain circumstances, are going to come into these protections on a different calendar.

Madam President, we have tried to include people who are going to have coverage from insurance. We are going

to respect the contract. When those insurance contracts expire, whether it is in January, whether in July, the protections go into effect. The same is true of the collective bargaining agreement. We have done that in other times. It has worked, and worked effectively. As I say, I believe the consumers, as well as employers—the employers from whom we have heard, and we have had many examples—indicate they cannot wait to get these protections in place. It isn't that people will delay getting in; it will be because they want to get in and get in more quickly.

The PRESIDING OFFICER. Leader time has expired.

Mr. NICKLES. I ask unanimous consent for 2 additional minutes.

Mr. KENNEDY. Then I ask for 4, 2 each side.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. NICKLES. A couple comments. The average length of collective bargaining agreements: 66 percent of collective bargaining agreements with over 1,000 employees—that is over 1,200 collective bargaining agreements—the average length is 3 to 5 years; 28 percent are 5 to 6 years; an additional 7 percent are 6 to 8 years.

My point is these things last for years. People renegotiate their health care plan. Federal employees do this every year. Almost everybody does it every year. So for the health care plan for everybody else in the private sector, you have to comply by next October, 12 months from now, maybe even January of next year; you will have to comply. But if you are in a collective bargaining plan, you wait until the plan terminates.

We asked the Department of Labor, does the plan terminate if renegotiated and rolled over? Not necessarily.

In collective bargaining, you are talking about 30 million Americans who will not receive the so-called benefits under this bill. That is a fact.

Another fact: My colleague said we supported an amendment by Senator COLLINS that said let the States use their State protections. I strongly agree with that. That is a reason I will vote against the underlying bill, because I don't think we should preempt States as the Kennedy-McCain bill does. I believe in that strongly. I know my friends and colleague from Massachusetts have a different belief. We could debate that for hours.

My point is, if the patient protections are so good—and I heard many sponsors say we should cover all Americans—the bill does not cover all Americans. As a result of the language we have been debating, collectively bargaining agreements are exempt for years. The bill we are debating now does not cover public plans; it does not cover Medicaid; it does not cover Medicare; it does not cover public employees; it does not cover the military; it does not cover veterans; it does not cover Federal employees.

We have control over Federal employees. If the patient protections are so good for the private sector, why not for collective bargaining plans as well?

Mr. KENNEDY. Madam President, it is interesting to listen to my friend and colleague. The fact is, the last President, President Clinton, put those in through Executive orders to cover those because of the delay of the Republican leadership in letting us get through this bill over the last 5 years. So rather than wait and wait and wait, we had a Democratic President put them into effect.

Now if a collective bargaining unit or contract expires on October 2, they go in prior to the time of the insurance coverage. They will go in months ahead of the insurance. If the contract expires on October 5, that goes in before July of the next year. So they get more protections than those being covered by the insurance.

This is just a way of saying if the contracts are out there, we are going to respect the termination of those contracts, whether it is in the insurance or in collective bargaining. Evidently, the Senator wants to use this as a device to punish some of their enemies, the unions in this case, to try to use the legislative process to do so. I hope we will reject that.

Mr. NICKLES. I yield myself 5 minutes off the leader time.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. NICKLES. I thank my friend, Senator BROWNBACK. I am the third Senator squeezed in front of him, and he has shown great patience. I will be brief.

My colleague from Massachusetts said President Clinton gave these protections to Federal employees because he couldn't wait for the Republican Congress to pass them.

The facts are, Federal employees do not have patient protections that are nearly as expensive, as aggressive, as intrusive as we are getting ready to impose on the rest of the private sector. I may have an amendment tomorrow to address that so we can save that for tomorrow's debate.

The patient protection that President Clinton passed is not nearly this big. Federal employees cannot sue their employer. When they have an appeal process, they do not go to an independent party; they go to OPM, Office of Personnel Management; they go to their employer. We do not do that in this bill. Maybe we will debate that tomorrow.

Finally, he said in collective bargaining plans, they have to be covered when the plan terminates. My point is the plan can be renegotiated. You are talking years. Sixty-six percent of collective bargaining plans are 3 to 5 years.

Then it says if they go ahead and implement it, it is not counted as a plan termination; therefore, it is not effective. Let's give union members the same protections we give all other private sector employees.

I thank my colleagues and my colleague from Massachusetts and particularly my colleague from Kansas for his patience in allowing us to go forward.

Mr. KENNEDY. I am prepared to yield back the time.

The PRESIDING OFFICER. All time is yielded back.

Mr. NICKLES. Madam President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

The PRESIDING OFFICER. The Senator from Kansas.

AMENDMENT NO. 847

Mr. BROWNBACK. I send an amendment to the desk for immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Kansas [Mr. BROWNBACK] proposes an amendment numbered 847.

Mr. BROWNBACK. I ask unanimous consent reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To prohibit human germline gene modification)

At the end of the bill, add the following:

**TITLE—HUMAN-GERMLINE GENE MODIFICATION**

**SEC. 01. SHORT TITLE.**

This title may be cited as the ''Human Germline Gene Modification Prohibition Act of 2001''.

**SEC. 02. FINDINGS.**

Congress makes the following findings:

(1) Human Germline gene modification is not needed to save lives, or alleviate suffering, of existing people. Its target population is ''prospective people'' who have not been conceived.

(2) The cultural impact of treating humans as biologically perfectible artifacts would be entirely negative. People who fall short of some technically achievable ideal would be seen as ''damaged goods'', while the standards for what is genetically desirable will be those of the society's economically and politically dominant groups. This will only increase prejudices and discrimination in a society where too many such prejudices already exist.

(3) There is no way to be accountable to those in future generations who are harmed or stigmatized by wrongful or unsuccessful human germline modifications of themselves or their ancestors.

(4) The negative effects of human germline manipulation would not be fully known for generations, if ever, meaning that countless people will have been exposed to harm probably often fatal as the result of only a few instances of germline manipulations.

(5) All people have the right to have been conceived, gestated, and born without genetic manipulation.

**SEC. 03. PROHIBITION ON HUMAN GERMLINE GENE MODIFICIATION.**

(a) IN GENERAL.—Title 18, United States Code, is amended by inserting after chapter 15, the following:

**''CHAPTER 16—GERMLINE GENE MODIFICATION**



**''§ 301. Definitions**

''In this chapter:

''(1) HUMAN GERMLINE GENE MODIFICATION.—The term 'human germline gene manipulation' means the intentional modification of DNA in any human cell (including human eggs, sperm, fertilized eggs, zygotes, blastocysts, embryos, or any precursor cells that will differentiate into gametes or can be manipulated to do so) for the purpose of producing a genetic change which can be passed on to future individuals, including inserting, deleting or altering DNA from any source, and in any form, such as nuclei, chromosomes, nuclear, mitochondrial, and synthetic DNA. The term does not include any modification of cells that are not a part of and will not be used to create human embryos. Nor does it include the change of DNA involved in the normal process of sexual reproduction.

''(2) HUMAN HAPLOID CELL.—The term 'haploid cell' means a cell that contains only a single copy of each of the human chromosomes, such as eggs, sperm, and their precursors.

''(3) SOMATIC CELL.—The term 'somatic cell' means a diploid cell (having two sets of the chromosomes of almost all body cells) obtained or derived from a living or decreased human body at any stage of development. Somatic cells are diploid cells that are not precursors of either eggs or sperm. A genetic modification of somatic cells is therefore not germline genetic modification.

Rule of Construction: Nothing in this Act is intended to limit somatic cell gene therapy, or to effect research involving human pluripotent stem cells.

**''§ 302. Prohibition on germline gene modification**

''(a) IN GENERAL.—It shall be unlawful for any person or entity, public or private, in or affecting interstate commerce—

''(1) to perform or attempt to perform human germline gene modification;

''(2) to intentionally participate in an attempt to perform human germline gene modification; or

''(3) to ship or receive the product of human germline gene modification for any purpose.

''(b) IMPORTATION.—It shall be unlawful for any person or entity, public or private, to import the product of human germline gene modification for any purpose.

''(c) PENALTIES—

''(1) IN GENERAL.—Any person or entity that is convicted of violating any provision of this section shall be fined under this section or imprisoned not more than 10 years, or both.

''(2) CIVIL PENALTY.—Any person or entity that is convicted of violating any provision of this section shall be subject to, in the case of a violation that involves the derivation of a pecuniary gain, a civil penalty of not less than $1,000,000 and not more than an amount equal to the amount of the gross gain multiple by 2, if that amount is greater than $1,000,000.''.

(b) CLERICAL AMENDMENT.—The table of chapters for part I of title 18, United States Code, is amended by inserting after the item relating to chapter 15 the following:

''16 Germline Gene Modification ..... 301''.

Mr. BROWNBACK. Madam President, I rise today to offer an amendment to the Patients' Bill of Rights. This amendment is about human germline gene modification. That is a long way of saying—and I will go into this for a period of time—stopping people from attempting to modify the human species with outside genetic material. It may seem strange. It happens in livestock, genetically modified organisms. Some people are researching and discussing doing this within the human species to create better people. I think it should be stopped, prohibited, removed.

I looked for a better vehicle for this amendment, for another bill that was a closer fit. It is a medical issue on the medical front. If we get an agreement that I get a freestanding bill, I will do it that way. Having not been able to do that, we offer it as an amendment now.

My amendment prohibits human germline gene modification. What is that? Technically, it is the process by which the DNA of an individual is permanently changed in such a way that it permanently affects his or her offspring. Normally this is a DNA modification in either the egg or the sperm within the human species, so when they combine, that genetic modification is carried in that person and in future organisms, in future people. So it starts at this single stage, the egg or the sperm, molded together and multiplied in future generations.

This is not about genetic therapy; it is not about stem cell research; it is not about human cloning. All those are other issues for another day that do need to be considered but not here. My amendment in no way hinders genetic therapy or other medical interventions that treat patients suffering from diseases.

My amendment is about eugenics. For those not familiar, that is the process or means of race improvement previously tried by many diabolical methods or schemes, generally looked at as restrictions of mating, of so-called superior people together, and now being attempted, talked about, pressed forward by adding genetic material of humans from outside the species.

This is ugly stuff, and it should be stopped. It is about what we as a society are willing to allow and not to allow. The issue of germline genetic modification is about our ability to create designer babies, choose eye color, height, or IQ. I offer this amendment, well aware that many of my colleagues understandably may be unaware of these so-called advances being made in the field of biotechnology and the impact those advances will inevitably have on the human race.

I come from an agricultural background. I used to be a Secretary of Agriculture in Kansas. These are things we commonly do now in plants, and we are having research done extensively in animals. People are talking about bringing some of the same technology to humans. It has to be stopped and should be stopped.

Many of the advances promise great achievement for mankind and a betterment of human conditions. Some of the advancements in biotechnology do not. Human germline gene manipulation is one of those. It is one of those advances discussed mostly in theoretical terms until recently. More disturbingly, it is the realization of the age-old quest to design better people. Germline gene manipulation is the summit of the eugenics movement. One of the groups we have consulted with prior to preparing this amendment is a group chaired by Claire Nader, the sister of former Presidential candidate Ralph Nader. It is a group she has been associated with, the Council for Responsible Genetics. They are unequivocally opposed to human germline gene modification.

The Council states this:

We strongly oppose the use of germline gene modifications in humans.

They continue:

Today, public discussion in favor of influencing the genetic constitution of future generations has gained new respectability with the increased possibility for intervention. Although it is once again espoused by individuals with a variety of political perspectives, modern eugenic programs are now defended as driven by individual need, choice. But the doctrine of social advancement through biological perfectibility underlying the new eugenics is even more potent than the older version. Its supporting data seem more scientifically sophisticated and the alignment between the state, through its support of the market and the individual exercising so-called free choice, is unprecedented.

The Council goes on to state further:

These considerations make the social and ethical problems raised by germline gene modification very different from those raised by genetic manipulations, that target certain nonreproductive deficiencies in organs of patients, again in somatic cell gene modification.

As the Council states in very clear terms:

The underlying political philosophy of those who support germline gene modification has been sanitized with new terms, but is in reality the same old eugenic message with which the 20th century was deeply and direly afflicted. In numerous conversations that I have had with Dr. Francis Collins, who heads the National Human Genome Research Institute here in Washington, who has had a fantastic report that was out last year on the Human Genome Project, reported out a beautiful array of the complexity of the genetic structure in each and every one of our 10 trillion cells and if we printed out that genetic structure and had it in front of us, it would be a stack of paper 100 feet taller than the Washington monument.

We have talked about the beauty of the human genome and also talked about the potential for problems in its manipulation, as that could be carried onto future humans.

Madam President, human germline gene modification is not needed to save lives or alleviate suffering of existing people. Its target population is prospective people who have not been conceived. The cultural impact of treating humans as biologically perfectible artifacts would be entirely negative. People who fall short of some technically achievable ideal would be seen as damaged goods, while the standards for what is genetically desirable would be those of the society's economically and politically dominant group. We have heard these themes before. This will only increase prejudices and discrimination in a society which already has too many of these.

There is no way to be accountable to those in the future generations who are going to be harmed or stigmatized by the wrongful or unsuccessful human germline gene modification of their ancestors. The negative effects of human germline modification would not be fully known for generations, if ever, meaning that countless people will have been exposed to harm, probably often fatal, as a result of only a few instances of germline manipulations.

All people have the right to be conceived, gestated, and born without genetic manipulation. Human germline gene manipulation will only serve to turn human beings into commodities with traits that are bought and sold, with attributes that are determined by technicians, and parents who want to exert genetic tyranny over their offspring. This is a step too far. This is grossly unethical for it to happen. I urge the Senate to adopt my amendment to prohibit it once and for all.

Again I put forward, in layman's terms, what this is about. This is about getting and adding outside genetic material into the human species, whether it be plant—tomato—or animal—chicken—from a tree somewhere that a snippet of genetic material would be added in, at the egg or the sperm level. Once added in there, when the union occurred it would be in that human and also then passed on to future generations. That is what we are talking about here. It is not about any sort of gene therapy or any of the other issues. It is not about cloning either, which is the identical replication. This is adding in the outside genetic material.

I think everybody would look at this and say that is not a road we want to go down. Yet some people today are contemplating doing this.

I want to add a couple of other points. The European Council on Biomedics has stated its opposition to this human germline gene modification. I think the civilized world really needs to step up right now, before people get going and moving forward, saying: We could make people taller. We could make people live longer by this modification. We found a gene line in trees that we could put in earlier, to the human species, and cause this to happen. We have a way to manipulate or change this—without knowing in any way down in future generations what this impact is.

We can send a strong, clear signal at this point in time that we want nothing to do with this, that this is wrong, this is eugenics, this is the height of eugenics, and it should not take place. The Europeans are moving that way. We should as well as much of the rest of the civilized world, and say we want no part of this, and we can do that with a clear, I hope unanimous, vote of the Senate, saying this is wrong.

I know people differ on some of these other biotechnology issues, such as cloning. That is left for another day. The language in this bill is clear, specific; it is easy to understand. We may have differences on some of the other issues we may get into over a period of time, but this is one, as I have searched around, where there is a broad coalition, left and right, that says yes, this one should be banned. That is why we worked closely with Ms. Nader's group, consulted with biotechnology groups, who were saying: Yes, this is not a place we should be going either. Here is a place we can stop this.

This is the only vehicle I could see where there was some connection bringing this up. If we could do it on a freestanding bill at some time on the floor, I would be happy to do that, but absent that, I would like to get this considered on this bill.

I yield the floor. I don't know that there is a time agreement on this amendment. Is that correct?

The PRESIDING OFFICER. There is a time agreement. There is 1 hour evenly divided.

Mr. BROWNBACK. Thank you, Madam President.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Madam President, I want to express a great deal of respect for my friend and colleague for his concern and interest in a great variety of different public policy issues, and also their ethical implications. He studies these issues. He is concerned about them. He brings them into the public debate and discussion. We always listen with great interest to his presentations on these matters because he has given this a great deal of thought.

Even so, I must rise to oppose this amendment. I can understand the good Senator's frustration that we do not have a real opportunity to have the kind of debate on a freestanding bill that could give the Senate the benefit of a good discussion on this issue. Unfortunately, we are here at 20 minutes of 10. There are just a few of us here at this time, and we will only have a few minutes tomorrow to deal with an issue of enormous importance and consequence.

Millions of American children are born with deadly diseases such as cystic fibrosis and muscular dystrophy that result from flaws in the DNA code. One of the most promising ways to cure these afflictions is to correct these DNA errors using gene therapy. If these flaws could be corrected before birth, millions of children could live their entire lives free of the debilitating symptoms of cruel genetic disorders.

Yet the Brownback amendment would ban any attempt to cure children of deadly disorders such as cystic fibrosis and muscular dystrophy by correcting their DNA flaws before birth.

It even goes so far as to imprison doctors who try to save their lives and relieve their suffering.

The Brownback amendment is opposed by a wide range of organizations representing patients, doctors, scientists, and the biotechnology industry. They know this amendment would have a chilling effect on the biomedical research that gives hope to millions of Americans at risk for genetic diseases.

The amendment is so broad that it will criminalize several promising areas of biomedical research, even including gene therapy in adults.

This important, complex topic deserves a thoughtful and measured response, and not the indiscriminate prohibition that the Brownback amendment proposes.

The American people do not support the sweeping prohibitions that the Brownback amendment would impose.

A recent study funded by the NIH conducted by the University of Michigan found that 65 percent of the public opposed a ban on prenatal gene therapy, and only one in five of those support such a ban.

There are great numbers of genetic diseases, and there are great numbers of inherited diseases. Those that come to mind quickly are cystic fibrosis and muscular dystrophy, Tay-Sachs, Cooley's disease, and many others in the cystic fibrosis area.

It is basically an issue involving a single gene. That is also true in muscular dystrophy.

Just think if we were able to get to the point where a parent would be able to see the alteration of that gene so that the child that was going to be born would be free from muscular dystrophy or from cystic fibrosis by altering the DNA.

We can easily understand where the language that is included may not be the purpose of the Senator, but certainly the language I think is sufficiently vague as to prohibit some promising research.

At this time, I think this is a matter of enormous importance. I don't think we really ought to be dealing with this issue on this bill.

I can understand the Senator's frustration in not being able to have the debate in the Senate and to hear the different views on this issue. But I believe we ought to defeat the amendment for now, have additional review and study and hearings, and that we ought to then consider the various public policy issues and the ethical issues that surround it.

Mr. REID. Madam President, will the Senator yield?

Mr. KENNEDY. Yes.

Mr. REID. I would like to ask the Senator a question. A couple of years ago when I was chairman of the Democratic Policy Committee, one of the issues at the time was cloning, for lack of a better description. We had a luncheon at the Democratic Policy Committee. This may not be directly in point, but it points up what the Senator is saying. This is a very complex issue. We need more time and medical expertise to respond to this.

But the Senator will remember that we had a hematology professor from Harvard. We had the leading expert on gene therapy at NIH. The Senator will

recall a number of things. The thing that is so vivid in my mind is the Harvard professor, who was of course a practicing physician, gave an example of how progress is being made in the medical field and in the areas that need more study.

He said that a young woman with leukemia was referred to him. I do not know the scientific name nor the type of leukemia. He did the examination and looked at the information he had been given.

The Senator will recall that the doctor asked this young lady if she had a brother or sister. She said no. He said that right then he knew she was in big trouble. She probably couldn't make it and would die.

The next day, the Senator will recall, another teenager came in with leukemia. It was the same process. He asked this young man if he had a brother or sister. He said no, and paused for a second. He said: I am a twin. The doctor said that he knew right then that the young man was going to live as long as anybody in this room because they could do a bone marrow transplant and regenerate those cells.

I don't fully understand what the Senator from Kansas is advocating with his amendment. I know he is candid and is well placed. I know after having listened to the woman from NIH and the professor from Harvard that I have great hope progress is being made on some of the most dreaded diseases that face especially children in America today.

The Senator from Massachusetts and I know how well-intentioned the Senator from Kansas is. I think we should defeat this amendment and wait for a later day so we can have more opportunity to examine this more closely.

The Senator remembers that meeting in the room right down the hall here?

Mr. KENNEDY. I do remember. All of us as Members of this body get a chance to go out to NIH and visit with the researchers and listen, watch, and hear about those extraordinary, dedicated men and women who are dealing with so much of the cutting edge research.

I think we want to make sure that we are very careful in the steps we are going to take that in some way would inhibit research. There are obviously strong ethical issues which we constantly have to examine and consider.

But I am very much concerned about the kind of prohibition that this type of amendment would include.

I want to make it clear that the amendment that the Senator from Kansas puts forward does not ban cloning, but it would ban similar cutting edge research.

That is what our concern is and why we will oppose it tomorrow.

The PRESIDING OFFICER. The Senator from Kansas.

Mr. BROWNBACK. Madam President, I would like to correct some miscalculation with the Senator from Massachusetts. I want to read from the amendment because he represented a couple of examples that we specifically state in the bill we are not prohibiting.

On page 4 of the amendment under ''construction,'' it states specifically that:

> Nothing in this Act is intended to limit somatic cell gene therapy, or to effect research involving human pluripotent stem cells.

This somatic cell gene therapy is what you are talking about where you have already the sperm and egg, and you have a full chromosome. That is where you may want to make changes, and that is where the research is focused. Now they can deal with some of the dreaded diseases the Senator from Massachusetts says we should rightly try to deal with. I agree that we should.

We specifically added that. We covered that point the Senator raised and about which he has concern because we don't want to impact that area. We talk about this on page 3. It says:

> The term ''human germline gene modification'' means the intentional modification of DNA in any human cell for the purpose of producing a genetic change which can be passed on to future individuals.

In this amendment we are saying: Do we really want to change the human species without knowing what the impact is going to be down the road? Maybe we have a shot at changing this one, but what is it going to do to the next generation, the second one, the third one, the fourth one, and after that?

I also point out to the good Senator who has worked tirelessly to get this bill through to passage—I appreciate both his work and the work of the Senator from Nevada on just continuing to press forward. They have done a very good job. But I point out to them that we have significant limitations on doing this to animals. Right now, if you wanted to take a fish and put a tomato germline in it, or something from a tomato gene—actually this is being done—this is a heavily regulated area by FDA, and the USDA, as well it should be. My goodness, do we want to get super fish out here that could swim and do things and take over a whole area of species? They are actually concerned. It may sound scientific, like this is just off the wall. But this is happening today.

We have these deep concerns within our society. You do not have to listen to me. The Senator from California knows what is taking place this week in southern California. People are deeply concerned about this being done with animals and plants.

All I am talking about with this amendment is to say, the careful thing for us to do right now is to prohibit it in humans.

As the Senator from Massachusetts knows, in any future legislative session we can remove that prohibition. We could do that next year. But wouldn't the careful, thoughtful thing be to say right now: ''We don't want to modify the human species''? It has no regulation, no limitation, no review on it today. People are out there doing these things.

Wouldn't the really thoughtful position be that we should stop this because we don't know its impact down the road—stop this now—and then, if the researchers really convince us this is the right thing to do, we can open it back up? I think we open up an incredible Pandora's box if we allow this unregulated area of human experimentation to continue at this time. And that is what is being defended here.

I think this should give us some thoughtful consideration. This is limited in its drafting. We have worked with a number of groups on its drafting. It is very specific. This has to do with it being passed down to future generations. This is something that we should prohibit at this time.

Madam President, I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Madam President, there are several organizations that draw different conclusions about the Senator's amendment. You have the Biotechnology Industry Organization that says:

> Unfortunately, the Brownback amendment reaches far beyond germ line gene modification. It attempts to regulate genetic research—a complex and dynamic field of science that holds great potential for patients with serious and often life-threatening illnesses.

And from the Association of American Medical Colleges:

> Much more troubling, however, the amendment reaches far beyond germ line therapy. Taken on its face, the amendment would prohibit other areas of research into gene therapy as well.

I ask unanimous consent an analysis be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

MEMORANDUM

JUNE 28, 2001.

To: Michael Werner, Esquire, BIO Bioethics Counsel.

From: Edward L. Korwek, Ph.D., J.D.

Re: Some Initial Comments/Analysis of the Brownback Amendment.

The Brownback Amendment is poorly worded and confusing as to its precise coverage. It uses a variety of scientific terms and other complex language both to prohibit and allow certain gene modification activities. Many of the sentences are composed of language that is incorrect or ambiguous from a scientific standpoint. A determination needs to be made of what each sentence of the Amendment is intended to accomplish.

As to a few of the important definitions, the term ''somatic cell'' is defined in proposed section 301(3) of Chapter 16, as ''a diploid cell (having two sets of the chromosomes of almost all body cells) obtained or derived from a living or deceased human body at any stage of development.'' What does ''of almost all body cells'' mean? Is this an oblique reference to the haploid nature of human sex cells, *i.e.*, sperm and eggs? Also, why is it important to describe in such confusing detail from where the cells are derived (in contrast to simply saying, for example, a

somatic cell is a human diploid cell)? From a scientific standpoint, the definition of a somatic cell is not dependent on whether the cell is from living or dead human beings. More importantly, as to this human source issue, when does a ''human body'' exist such that its status as ''living'' or ''dead'' or its ''stages of development'' become relevant criteria for determining what is a ''somatic cell.''

Similarly, the definition of ''human germline modification,'' especially the first sentence, is very convoluted. The first sentence states:

''The term 'human germline gene modification' means the intentional modification of DNA of any human cell (including human eggs, sperm, fertilized eggs (i.e., embryos, or any early cells that will differentiate into gametes or can be manipulated to do so) for the purpose of producing a genetic change which can be passed on to future individuals, including DNA from any source, and in any form, such as nuclei, chromosomes, nuclear, mitochondrial, and synthetic DNA.''

Among other problems, which of the examples listed are ''sources'' or ''forms'' of DNA and why does it matter? Moreover, the sentence ends by referring to ''including DNA from any source, and in any form, such as nuclei, chromosomes, nuclear, mitochondrial, and synthetic DNA.'' To what part of the first sentence defining ''human germline modification'' is this language referring? Does the last sentence of the definition, ''Nor does it include the change of DNA involved in the normal process of sexual reproduction'' prohibit *in vitro* fertilization? Does any other part of the Amendment prohibit or allow *in vitro* fertilization? What genetic technologies does ''normal'' cover, if any?

Similarly, the second sentence in the definition, stating what is not covered by the definition of ''human germline modification,'' contains three ''not'' words, leaving the reader to decipher what exactly is ''not'' ''human germline modification'': ''The term does not include any modification of cells that are not a part of and will not be used to construct human embryos'' (emphasis added). Also, what is an ''embryo'' for purposes of this Amendment and what does ''part of'' mean? Are (fertilized) sex cells ''part of'' an embryo?

These and other problems leave the bill unsupportable in its current form. Due to this imprecision, the amendment's impact is unclear and seemingly far reaching.

Mr. KENNEDY. Madam President, a memorandum by Hogan & Hartson says:

The Brownback Amendment is . . . confusing as to its precise coverage. It uses a variety of scientific terms and other complex language both to prohibit and allow certain gene modification activities.

And it gives a several-page analysis of this.

The fact is, as I understand it, there is a moratorium now at NIH. NIH does not permit any of the research in transferring of the materials in terms of genes at the present time.

I just mention quickly, on page 3 of the amendment, on lines 10 and 11, it talks about ''for the purpose of producing a genetic change which can be passed on to future individuals . . .'' That ought to be a matter of concern to parents because that is an area of very great potential in terms of parents who have the gene—in terms of cystic fibrosis, muscular dystrophy—in trying to impact that kind of DNA so that they will not pass this on. Yet this is talking about restricting the research for ''producing a genetic change which can be passed on to future individuals . . .'' That very area is a matter of enormous importance and consequence.

I know the Senator has given this a lot of thought. It is enormously important. I respect him for it. I know that he revisits these issues continuously. We will look forward to continuing to work with him. I know he is incredibly concerned about the broad areas of ethical issues. In those areas of ethical concerns there are no simple, easy answers. There is enormous division, significant divisions, in many different areas.

But it does seem to me that in the time that we have available to consider this, and on this particular legislation, and with the very strong opposition of the research community generally, that it would be unwise for us to add this at this time to the legislation.

The PRESIDING OFFICER. The Senator from Kansas.

Mr. BROWNBACK. Madam President, I would just note once more for my colleagues that the area of genetic manipulation, germline therapy, is regulated in animals and in plants but is completely unregulated—there is nothing on it—in humans.

Is that a responsible way for us to go? There is nothing on it. If we want to do it right now on the human species in the United States, go ahead, fine. If you want to do that, release that into us, into the human species, fine, go ahead. If you want to do it in fish, we have a series of hoops that you have to jump through and filings that you have to make and limitations on where this can take place all up and down, everywhere. But for humans, fine. I guess if we are going to eat it, we are concerned about it. But if it is one of us, OK.

I have deep respect for the Senator from Massachusetts. He is very thoughtful and one of the most productive Members of this body, probably in the history of this body. But I would really seriously ask him to look at this area. Is this something we want to do in this society? This is not only technically or theoretically feasible today; it can be done today. It has been done in the animal line for years now. This has been going on for 10 years-plus, 15 years in animals. The genetic lineup in animals versus humans is not that much different. Totally unregulated, no limitations—go ahead and do it in humans, not in cattle.

I would hope we could at least get some agreement that this is going to be further considered sometime during this legislative session. If we want more limited language, I am more than happy to work with individuals in drafting more limited language. If there is concern about gene therapy on it, I am willing to draft it as tight as they want to on gene therapy. That would be just fine by me. But to let this go on now, you are inviting people to step up. If we need to work with the groups the Senator listed to draft it more tightly, I am happy to do that.

This is a serious matter. We have more and more people in the streets protesting about this very thing. I think we should wake up on that particular point, if nothing else. We saw the protest that took place in Seattle. We saw what it did to the World Trade talks. That was on food. We are seeing what is taking place in the Biotechnology Expo in Southern California right now. That is on humans.

This issue is not going away. It is something that we are going to have to confront. I would hope and I would think we would be far wiser to do it sooner rather than later. I am happy to work with anybody on drafting the language to see that that takes place.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. I will include the regulations which are in existence now. I ask unanimous consent they be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From pages 90–92—NIH Guidelines for Research Involving Recombinant DNA Molecules]

Appendix K–VII–K. Pathogen. A pathogen is any microbiological agent or eukaryotic cell containing sufficient genetic information, which upon expression of such information, is capable of producing disease in healthy people, plants, or animals.

Appendix K–VII–L. Physical Barrier. A physical barrier is considered any equipment, facilities, or devices (e.g., fermentors, factories, filters, thermal oxidizers) which are designed to achieve containment.

Appendix K–VII–M. Release. Release is the discharge of a microbiological agent or eukaryotic cell from a containment system. Discharges can be incidental or accidental. Incidental releases are de minimis in nature; accidental releases may be de minimis in nature.

Appendix L. Gene Therapy Policy Conferences (GTPCs)

In order to enhance the depth and value of public discussion relevant to scientific, safety, social, and ethical implications of gene therapy research, the NIH Director will convene GTPCs at regular intervals. As appropriate, the NIH Director may convene a GTPC in conjunction with a RAC meeting. GTPCs will be administered by NIH/OBA. Conference participation will not involve a standing committee membership but rather will offer the unique advantage of assembling numerous participants who possess significant scientific, ethical, and legal expertise and/or interest that is directly applicable to a specific gene therapy research issue. At least one member of RAC will serve as Cochair of each GTPC and report the findings of each GTPC to RAC at its next scheduled meeting. The RAC representative for each GTPC will be chosen based on the participant's area of expertise relative to the specific gene therapy research issue to be discussed. All RAC members will be invited to attend GTPCs. GTPCs will have representation from other Federal agencies, including FDA and OPRR. GTPCs will focus on broad overarching policy and scientific issues related to gene therapy research. Proposals for GTPC topics may be submitted by members

of RAC, representatives of academia, industry, patient and consumer advocacy organizations, other Federal agencies professional scientific societies, and the general public. GTPC topics will not be limited to discussion of human applications of gene therapy research, i.e., they may include basic research on the use of novel gene delivery vehicles, or novel applications of human gene transfer. The RAC, with the Director's approval, will have the primary responsibility for planning GTPC agendas. GTPC findings will be transmitted to the NIH Director and will be made publicly available. The NIH Director anticipates that this public policy forum will serve as a model for interagency communication and collaboration, concentrated expert discussion of novel scientific issues and their potential societal implications, and enhanced opportunity for public discussion of specific issues and potential impact of such applications on human health and the environment.

Appendix M. Points to Consider in the Design and Submission of Protocols for the Transfer of Recombinant DNA Molecules into One or More Human Research Participants (Points to Consider)

Appendix M applies to research conducted at or sponsored by an institution that receives any support for recombinant DNA research from NIH. Researchers not covered by the NIH Guidelines are encouraged to use Appendix M (see Section I–C, General Applicability).

The acceptability of human somatic cell gene therapy has been addressed in several public documents as well as in numerous academic studies. In November 1982, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research published a report, Splicing Life, which resulted from a two-year process of public deliberation and hearings. Upon release of that report, a U.S. House of Representatives subcommittee held three days of public hearings with witnesses from a wide range of fields from the biomedical and social sciences to theology, philosophy, and law. In December 1984, the Office of Technology Assessment released a background paper, Human Gene Therapy, which concluded that civic, religious, scientific, and medical groups have all accepted, in principle, the appropriateness of gene therapy of somatic cells in humans for specific genetic diseases. Somatic cell gene therapy is seen as an extension of present methods of therapy that might be preferable to other technologies. In light of this public support, RAC is prepared to consider proposals for somatic cell gene transfer.

RAC will not at present entertain proposals for germ line alterations but will consider proposals involving somatic cell gene transfer. The purpose of somatic cell gene therapy is to treat an individual patient, e.g., by inserting a properly functioning gene into the subject's somatic cells. Germ line alteration involves a specific attempt to introduce genetic changes into the germ (reproductive) cells of an individual, with the aim of changing the set of genes passed on to the individual's offspring.

The RAC continues to explore the issues raised by the potential of in utero gene transfer clinical research. However, the RAC concludes that, at present, it is premature to undertake any in utero gene transfer clinical trail. Significant additional preclinical and clinical studies addressing vector transduction efficacy, biodistribution, and toxicity are required before a human in utero gene transfer protocol can proceed. In addition, a more thorough understanding of the development of human organ systems, such as the immune and nervous systems, is needed to better define the potential efficacy and risks of human in utero gene transfer. Prerequisites for considering any specific human in utero gene transfer procedure include an understanding of the pathophysiology of the candidate disease and a demonstrable advantage to the in utero approach. Once the above criteria are met, the RAC would be willing to consider well rationalized human in utero gene transfer clinical trials.

Research proposals involving the deliberate transfer of recombinant DNA, or DNA or RNA derived from recombinant DNA, into human subjects (human gene transfer) will be considered through a review process involving both NIH/OBA and RAC. Investigators shall submit their relevant information on the proposed human gene transfer experiments to NIH/OBA. Submission of human gene transfer protocols to NIH will be in the format described in Appendix M–1, Submission Requirements—Human Gene Transfer Experiments. Submission to NIH shall be for registration purposes and will ensure continued public access to relevant human gene transfer information conducted in compliance with the NIH Guidelines. Investigational New Drug (IND) applications should be submitted to FDA in the format described in 21 CFR, Chapter 1, Subchapter D, Part 312, Subpart B, Section 23, IND Content and Format.

Institutional Biosafety Committee approval must be obtained from each institution at which recombinant DNA material will be administered to human subjects (as opposed to each institution involved in the production of vectors for human application and each institution at which there is ex vivo transduction of recombinant DNA material into target cells for human application).

Factors that may contribute to public discussion of an human gene transfer experiment by RAC include: (i) new vectors/new gene delivery systems, (ii) new diseases, (iii) unique applications of gene transfer, and (iv) other issues considered to require further public discussion. Among the experiments that may be considered exempt from RAC discussion are those determined not to represent possible risk to human health or the environment. Full RAC review of an individual human gene transfer experiment can be initiated by the NIH Director or recommended to the NIH Director by: (i) three or more RAC members, or (ii) other Federal agencies. An individual human gene transfer experiment that is recommended for full RAC review should represent novel characteristics deserving of public discussion. If the Director, NIH, determines that an experiment will undergo full RAC discussion, NIH/OBA will immediately notify the Principal Investigator. RAC members may forward individual requests for additional information relevant to a specific protocol through NIH/OBA to the Principal Investigator. In making a determination whether an experiment is novel, and thus deserving of full RAC discussion, reviewers will examine the scientific rationale, scientific context (relative to other proposals reviewed by RAC), whether the preliminary in vitro and in vivo safety data were obtained in appropriate models and are sufficient, and whether questions related to relevant social and ethical issues have been resolved. RAC recommendations on a specific human gene transfer experiment shall be forwarded to the NIH Director, the Principal Investigator, the sponsoring institution, and other DHHA components, as appropriate. Relevant documentation will be included in the material for the RAC meeting at which the experiment is scheduled to be discussed. RAC meetings will be open to the public except where trade secrets and proprietary information are reviewed (see Section IV–D–5, Protection of Proprietary Data). RAC prefers that information provided in response to Appendix M contain no proprietary data or trade secrets, enabling all aspects of the review to be open to the public.

Note: Any application submitted to NIH/OBA shall not be designated as 'confidential;' in its entirety. In the event that a sponsor determines that specific responses to one or more of the items described in Appendix M should be considered as proprietary or trade secret, each item should be clearly identified as such. The cover letter (attached to the submitted material) shall: (1) clearly indicate that select portions of the application contain information considered as proprietary or trade secret, (2) a brief explanation as to the reason that each of these items is determined proprietary or trade secret.

Public discussion of human gene transfer experiments (and access to relevant information) shall serve to inform the public about the technical aspects of the proposals, meaning and significance of the research, and significant safety, social, and ethical implications of the research. RAC discussion is intended to ensure safe and ethical conduct of gene therapy experiments and facilitate public understanding of this novel area of biomedical research.

In its evaluation of human gene transfer proposals, RAC will consider whether the design of such experiments offers adequate assurance that their consequences will not go beyond their purpose, which is the same as the traditional purpose of clinical investigation, namely, to protect the health and well being of human subjects being treated while at the same time gathering generalizable knowledge. Two possible undersirable consequences of the transfer of recombinant DNA would be unintentional: (i) vertical transmission of genetic changes from an individual to his/her offspring, or (ii) horizontal transmission of viral infection to other persons with whom the individual comes in contact. Accordingly, Appendices M–I through M–V request information that will enable RAC and NIB/OBA to assess the possibility that the proposed experiment(s) will inadvertently affect reproductive cells or lead to infection of other people (e.g., medical personnel or relatives).

Appendix M will be considered for revisions as experience in evaluating proposals accumulates and as new scientific developments occur. This review will be carried out periodically as needed.

Appendix M–I. Requirements for Protocol Submission, Review, and Reporting—Human Gene Transfer Experiments

Appendix M–I–A. Requirements for Protocol Submission

The following documentation must be submitted (see exemption in Appendix M–VI–A, Footnotes of Appendix M) in printed or electronic form to the: Office of Biotechnology Activities, National Institutes of Health, 6705 Rockledge Drive, Suite 750, MSC 7985 Bethesda, MD. 20892–7985 (20817 for non-USPS mail), 301–496–9838, 301–496–9839 (fax), E-mail: rosenthg@od.nih.gov. NIH OBA will confirm receipt within three working days after receiving the submission. Investigators should contact OBA if they do not receive this confirmation.

1. A cover letter on institutional letterhead, signed by the Principal Investigator(s), that (1) acknowledge that the documentation submitted to NIH OBA compiles with the requirements set forth in Appendix M–I–A, Requirements for Protocol Submission: (2) identifies the Institutional Biosafety Committee (IBC) and Institutional Review Board (IRB) as the proposed clinical trial site(s) responsible for local review and approval of the

protocol; and (3) acknowledges that no research participant will be enrolled (see definition of enrollment in Section I–E–7) until the RAC review process has been completed (see Appendix M–I–B, RAC Review Requirements); IBC approval (from the clinical trial site) has been obtained; IRB approval has been obtained; and all applicable regulatory authorizations have been obtained.

2. The scientific abstract.

3. The non-technical abstract.

4. The proposed clinical protocol, including tables, figures, and relevant manuscripts.

5. Responses to Appendices M–II through M–V, Description of the Proposal, Informed Consent, Privacy and Confidentiality, and Special Issues. Responses to Appendices M–II through M–V may be provided either as an appendix to the clinical protocol or incorporated in the clinical protocol. If responses to Appendixes M–II through M–V are incorporated in the clinical protocol, each response must refer to the appropriate Appendix M–II through M–V.

Mr. KENNEDY. Finally, the reason there is a moratorium is there isn't reason to believe that this kind of research is safe today. But it may very well be safe tomorrow or the next day. And the possibilities, as I say, are unlimited. The action of the Senator may effectively close that window, close that door. I do not think that we ought to be in the position of doing that. So I have included the current state of the regulations that are in effect now in NIH and the reasons for those regulations.

Unless there is someone else who wants to speak on this——

The PRESIDING OFFICER. The Senator from Kansas.

Mr. BROWNBACK. Madam President, I would like to respond on that point as well. The FDA is saying they have authority over this. One of the groups they are seeking to regulate is saying they do not have authority, and they are going to sue them to keep the FDA from regulating them.

So regulations have been proposed, but it is a very open question about whether or not this applies to groups that are seeking to do this or seeking legal injunction prohibiting the FDA from regulating this. So we can put those on forward.

The fact is, this has not been dealt with, and it is of utmost importance to people in this country and around the world, and it should be. This should not happen during our watch.

The PRESIDING OFFICER. Does the Senator yield the remainder of his time?

Mr. BROWNBACK. Madam President, I ask for the yeas and nays.

The PRESIDING OFFICER. The yeas and nays have been requested.

Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. BROWNBACK. Madam President, I yield back the remainder of my time.

The PRESIDING OFFICER. Does the Senator from Massachusetts yield back his time?

Mr. KENNEDY. I yield back the remainder of my time.

The PRESIDING OFFICER. Who seeks recognition? The Senator from Nevada is recognized.

AMENDMENT NO. 849

(Purpose: To provide for genetic nondiscrimination)

Mr. ENSIGN. Madam President, I call up amendment No. 849 and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The senior assistant bill clerk read as follows:

The Senator from Nevada [Mr. ENSIGN] proposes an amendment numbered 849.

Mr. ENSIGN. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

Mr. ENSIGN. Madam President, the amendment that I have proposed really is entitled the ''protection against genetic discrimination act.'' The Senator from Massachusetts is one of the cosponsors of a bill that contains this particular amendment, along with 22 other Senators.

The mapping of the human genome is one of the most amazing scientific breakthroughs in recent history. Information that is embedded in the genome holds the key to understanding the illnesses and diseases that affect millions of people across the world every day.

I would like to note, this has nothing to do with the amendment that Senator BROWNBACK just proposed. We want to keep the controversies separate. What our amendment deals with is whether you can take this genetic information and use it to determine whether or not to provide health insurance coverage.

When the map of the human genome is completed, we will have all of the information that is contained in the 23 pairs of chromosomes in the human body. This information will be instrumental for finding the cure for diseases such as breast cancer, cystic fibrosis, Alzheimer's disease, and hundreds of other debilitating illnesses.

However, this breakthrough also carries great dangers. Current law does not provide any protections for individuals to keep their own genetic information private. Currently there is no law prohibiting a health plan from requiring an applicant to provide genetic information prior to the approval for insurance. In other words, any individual with a genetic marker for a specific disease would most likely not be able to receive health insurance coverage for the treatment of that disease.

A joint report by the Department of Labor, Department of Health and Human Services, the Equal Employment Opportunity Commission, and the Department of Justice summarized the various studies on discrimination based on genetic information and argued for the enactment of Federal legislation.

The report stated that:

Genetic predisposition or conditions can lead to work force discrimination, even in cases where workers are healthy and unlikely to develop disease, or where the genetic condition has no affect on the ability to perform work.

Because an individual's genetic information has implications for his or her family members and future generations, misuse of genetic information could have intergenerational effects that are broader than any individual incident of misuse.

Dr. Francis Collins, the director of the National Human Genome Research Institute, has stated:

While genetic information and genetic technology hold great promise for improving human health, they can always be used in ways that are fundamentally unjust. Genetic information can be used as the basis for insidious discrimination.

The misuse of genetic information has the potential to be, and is, a very serious problem both in terms of people's access to employment and health insurance and the continued ability to undertake important genetic research.

This amendment takes the first step toward providing individuals with the protections they need for their individual genetic information.

This amendment, as I mentioned before, is part of a larger bill that Senator DASCHLE has introduced on this very same subject. Simply put, this amendment prohibits health insurance companies from using genetic information when deciding whether or not to provide health insurance for an individual.

Insurance companies would not be able to use genetic information to deny an individual's application for coverage or charge excessive premiums.

Think about diseases such as Tay-Sachs, sickle-cell anemia, breast cancer, colon cancer, cystic fibrosis, and other diseases in which we have identified genes that predispose people to these diseases. Just think about how many Americans this affects now and will affect in the future as we discover new genes that predispose people to certain diseases. It is because of this that we must include this amendment if we are truly going to call this bill a Patients' Bill of Rights.

Madam President, my wife and I helped co-found the Breast Cancer Coalition of Nevada. Many of the women who are actively involved in this wonderful organization are breast cancer survivors or family members of women who have died from breast cancer. A wonderful friend of my wife and I, one of the most incredible women I have ever met, died in my wife's arms several years ago. She died of breast cancer. To think about women such as her who have had a gene identified, or maybe her daughter the same, to think about her someday being discriminated against getting health insurance is just unconscionable.

I encourage all of my Senate colleagues, including the sponsors of the bill, to accept this amendment. It is the right thing to do. I urge its adoption.

I yield the floor.

The PRESIDING OFFICER (Mr. CARPER). The Senator from North Carolina.

Mr. EDWARDS. Mr. President, we yield back the remainder of our time.

Mr. ENSIGN. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be.

The yeas and nays were ordered.

Mr. ENSIGN. Mr. President, I yield back the remainder of my time on this amendment.

AMENDMENT NO. 848

Mr. ENSIGN. Mr. President, I call up amendment No. 848 and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. ENSIGN] proposes an amendment numbered 848.

Mr. ENSIGN. Mr. President, I ask that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide that health care professionals who provide pro bono medical services to medically underserved or indigent individuals are immune from liability)

At the end, add the following:

**SEC. ___. IMMUNITY.**

(a) IN GENERAL.—Notwithstanding any other provision of law, no health care professional shall be liable for the performance of, or the failure to perform, any duty in providing pro bono medical services to a medically underserved or indigent individual.

(b) DEFINITIONS.—In this section:

(1) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' has the meaning given the term in section 151.

(2) MEDICALLY UNDERSERVED OR INDIGENT INDIVIDUAL.—The term ''medically underserved or indigent individual'' means an individual that does not have health care coverage under a group health plan, health insurance coverage, or any other health care coverage program, or who is unable to pay for the health care services that are provided to the individual.

Mr. ENSIGN. Mr. President, this next amendment I am offering comes once again from personal experience. I have a very close friend, Dr. Tony Alamo. He is a few years younger than me, and is an internist in Las Vegas. Our parents have known each other for a long time. He graduated from USC medical school. I don't know that I have ever seen anybody work harder.

Internists today don't make nearly the money that a lot of surgical specialists make, but the compassion that they have for their patients is just incredible. I remember a few years ago talking to him and what he had to tell me was amazing. As a practicing veterinarian, we get to choose who we take, who we don't take, and when they come into our offices. But as a physician, when he happens to be there treating another patient, if somebody comes in and he happens to be the attending physician, he has to treat that person, regardless of whether they have insurance or no insurance, can pay or cannot pay.

When he takes that person on as a patient, he cannot get rid of that patient. So he has to continue through the course of the disease, if he is in the hospital, has a heart condition, he has to continue regardless of whether he gets reimbursed or not.

The purpose of my amendment is to say we want them to continue that kind of care, but if out of the goodness of their heart they are treating for free, we just want to eliminate the possibility that they can be sued for such a matter.

We are looking at this as a situation that is similar to Good Samaritan laws. For example, when somebody stops on the side of the freeway because somebody is hurt and they don't know exactly what to do but they want to help and they happen to do more harm than good, we have passed laws across the country that helps a Good Samaritan in that regard.

The practice of medicine, as anybody who has practiced knows, whether it is veterinary medicine or human medicine, is both an art and a science. As a matter of fact, it is more art than science. Things go wrong. Sometimes things go wrong that may look like malpractice. And sometimes it is something the doctor had nothing to do with, yet they can still be taken to court.

Our amendment says that if health care professionals are going to do this, we want to protect those people from lawsuits.

It seems to me that if somebody is providing something out of the goodness of their heart on a pro bono basis, they could not be sued. In fact, I would support a similar proposal that granted lawyers the same protection. If they are providing pro bono services, they could not be sued. I think if this was a lawyer's bill of rights, we would include that as well. But this happens to be a Patients' Bill of Rights, and for the physicians that are treating these patients, we want to make sure they are protected.

We have spoken to Senator MCCAIN's staff and, apparently, they think the language is acceptable. I think in the long run this is going to go a long way. I have spoken to Senator FRIST who, as many of you know, is a heart surgeon. He does volunteer work in clinics, both overseas and also here in the United States. He doesn't get paid for these services. Yet, he has to maintain medical malpractice insurance. He pays premiums out of his pocket each year so that if he gets sued, he is covered.

This is probably the only amendment in this entire bill that actually will lower—it will only lower it slightly—the cost of health insurance. It would help lower both the cost of medical malpractice premiums and eventually the cost of coverage premiums for consumers as well.

Mr. President, I don't know if anybody is going to oppose this amendment. I can't understand why they would. I would be more than happy to engage in a debate on this if anybody has a problem with it.

I yield the floor at this time.

The PRESIDING OFFICER. The Senator from North Carolina is recognized.

Mr. EDWARDS. First, I say to the Senator from Nevada that Senator Coverdell had a bill that he passed called the Volunteer Protection Act of 1997. It specifically provides protection for volunteers, including physicians, who provide pro bono services. So I suggest to my colleague, I don't know if he thinks there is a problem with that law or the way it is written. There is no way for me to know that based on this amendment. But a specific law already covers this subject matter. It was passed by the Senate and signed into law in 1997. So, first, I suggest that my colleague look at that law and make sure what he is concerned about is not covered by it.

Second, this Bipartisan Patient Protection Act is about HMO reform. It is not about physician liability or the lack thereof—either of those. We would certainly have a problem with adding an amendment to this legislation that is not related to the issue of HMO reform.

So I say to my colleague, again, understanding that we are just seeing his amendment, in fairness, I will be happy to talk with him about it, but those were my immediate concerns. There appears to be a law that already covers this subject matter. We would always be concerned, of course, even under those circumstances, about a health care provider who acted recklessly. I don't know whether his amendment covers that or not.

Third, the general issue of adding these kinds of provisions to an HMO reform bill, which is what this bill is about, would also be a concern.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. First of all, physicians I have spoken to do not think the bill the Senator is talking about adequately covers them. That is why they still have to carry medical malpractice insurance, similar to what Senator FRIST has to carry. My amendment would help lower the cost of this type of coverage, so we think this bill is necessary. I don't understand—if this is already covered in law, why would it be a problem to include it to make sure we are saying to the courts that we absolutely want to cover people who are providing pro bono services to the needy.

Mr. EDWARDS. I say to my colleague that if there is already a law in place that covers this issue, it seems as a matter of procedure that the appropriate thing to do would be to amend the already existing law that covers the subject matter, as opposed to adding this measure to an HMO reform piece of legislation.

So I guess, just as a matter of orderly process, that would make sense to me.

Mr. ENSIGN. We have been looking for a vehicle to include this in. We have wanted to deal with this for some time.

This is a Patients' Bill of Rights, and I know it deals mostly with HMOs, but we are looking at our health care system and providing rights to patients. This is part of the health care bill that I think appropriately should have an amendment such as this, simply because I don't think there is any question that we are driving up health care costs in this country. If anything can help drive down, even a small amount, the cost of health care, I think we should do it.

If between now and tomorrow morning, if there is other language the Senator thinks we need to massage into our amendment, I would be more than happy to work with the Senator from North Carolina. But as it stands, we think this is an important amendment.

Mr. EDWARDS. Mr. President, I say to my colleague, I appreciate his comments. He and I are friends, and I would like to find a way to work on this. I will be happy to talk to him about this when we adjourn.

Having said that, I continue to have a significant concern about raising an issue on the HMO reform bill that is not related to HMO reform. We have pretty consistently throughout this debate opposed and defeated amendments unrelated to the coverage of this bill. There are obviously many subject matters that are related to the general area of health reform and health care. If we start adding amendments on all subjects of health care, we would never get this legislation completed and passed. I continue to have that concern.

I am happy to work with my colleague and listen to his concerns and work on language, although at this moment this is an amendment we would be compelled to oppose.

Mr. ENSIGN. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. REID. Mr. President, I ask unanimous consent that when the Senate resumes consideration of the Patients' Bill of Rights on Friday, June 29, at 9 a.m., the Senate proceed to vote in relation to the following amendments, and it be disposed of in the following order, with no second-degree amendments in order prior to the votes; further, that there be 4 minutes of debate prior to each vote, and that the first rollcall vote be 15 minutes in length and subsequent rollcall votes be 10 minutes in length. The order of the votes tomorrow morning would be: Santorum, DeWine, Grassley, Nickles, Brownback, Ensign No. 849, and Ensign No. 848.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, I indicated earlier in this debate that I would complete reading into the RECORD the names and titles of organizations that support the Patient Protection Act. Therefore the following is the final list:

Gateway; Gateways for Youth and Families in WA; George Junior Republic in Indiana; Gibault; Girls and Town in NE; Goodwill-Hinckley Homes for Boys; Greenbrier Children's Center; Growing Home in St. Paul, MN; Haddasah; Heart of America Family Services; Hemochromatosis Foundation; Hereditary Colon Cancer Association; Highfields, Inc. in Onondaga, MI; Holy Family Institute of Pittsburgh, PA; Home on the Range in Sentinel Butte in Sentinel Butte, ND; Hubert H. Humphrey, III—Former Minnesota Attorney General; Human Services, Inc.; IARCCA An Association of Children.

Idaho Youth Ranch; Indiana United Methodist Children; Infectious Disease Society of America; International Association of Psychosocial Rehabilitation Services; Jackson-Feid Homes in VA; Jane Addams Hull House Association; Jeffrey Modell Foundation; Jewish Board of Family & Children in New York, NY; Jewish Community Services of South Florida; Jewish Family & Career Services; Jewish Family & Children's Service in TX; Jewish Family & Children's Service in Minnetonka, MN; Jewish Family and Childrens Services; Jewish Family and Community Service; Jewish Family Service in Providence, RI; Jewish Family Service in Teaneck, NJ; Jewish Family Service in TX; Jewish Family Service of Akron, OH; Jewish Family Services of Los Angeles; Julia Dyckman Andrus Memorial Children's Center in NY; June Burnett Institute.

Kemmerer Village; Kentucky United Methodist Homes; KidsPeace National Centers, Inc. in PA; Lakeside, Kalamazoo, MI; LaSalle School, Inc. in Albany, NY; League of Women Voters; Leake and Watts Services, Inc. in Yonkers, NY; Learning Disabilities of America; Lee and Beulah Moor Children's Home in TX; Lupus Foundation of America; Lutheran Child & Family Service in Bay City, MI; Lutheran Child & Family Services; Lutheran Social Services of Wisconsin; Manisses Communications Group in RI; Maple Shade Youth & Family Services; Maryhurst, Inc.; Maryland Association of Resources for Families & Youth; Massachusetts Council of Family; Mental Fitness Center; Mental Health Liaison Group; MentalHealth AMERICA, Inc.; Methodist Children's Home in TX; Metropolitan Family Service of Portland, OR; Metropolitan Family Services of Chicago.

Michigan Federation of Private Child & Family Agencies; Mid-South Chapter of the Paralyzed Veterans of America; Milton Hershey School in Hershey, PA; Missouri Baptist Children's Home; Missouri Coalition of Children's Agencies; Missouri Girls Town; Mooseheart Child City and School; Morning Star Boys' ranch in WA; Mountain Community Resources; Namaqua Center; Natchez Children's Home in Natchez MS; National Alliance for the Mentally Ill; National Association for Rural Mental Health; National Association for the Advancement of Orthotics and Prosthetics; National Association of Children's Hospitals; National Association of County Behavioral Health Directors; National Association of Development Disabilities Councils; National Association of People with AIDS; National Association of Private School for Exceptional Children; National Association of Private Special Education Centers; National Association of Protection and Advocacy Systems; National Association of School Psychologists.

National Association of Social Workers; National Association of Wholesaler-Distributors; National Black Women's Health Project; National Breast Cancer Coalition; National Catholic Social Coalition; National Catholic Social Justice Lobby; National College of Osteopathic Emergency Physicians; National Community Pharmacists Association; National Consumers League; National Council for Community Behavioral Health; National Depressive and Manic-Depressive Association; National Down Syndrome Congress; National Family Planning and Reproductive Health Association; National Health Council; National Hemophilia Foundation; National Marfan Foundation; National Mental Health Association; National Multiple Sclerosis Society; National Organization of Physicians Who Care; National Organization of State Association for Children in MD; National Parent Network on Disabilities; National Partnership for Women and Families; National Patient Advocate Foundation; National Psoriasis.

National Rehabilitation Association; National Therapeutic Recreation Society; National Transplant Action Committee; National Women's Health Network; Nation's Voice on Mental Illness; Nazareth Children's Home in Rockwell, NC; NETWORK; New Community Corporation in Newark, NJ; Newark Emergency Services for Families in New Jersey; NISH; Norris Adolescent Center in WI; Northeast Parent & Child Society in New York; Northern Virginia Family Service; Northwest Chapter of the Paralyzed Veterans of America; Northwest Children's Home, Inc.; Northwood Children's Services in Duluth, MN; Oak Grove Institute Foundation; Oakland Family Services; Olive Crest Treatment Centers; Organization of Specialist in Emergency Medicine; Outcomes, Inc. in Albuquerque, NM; PA Alliance for Children and Families in Hummelstown, PA.

Pacific Lodge Youth Services; Paget Foundation; Pain Care Coalition; Palmer Home for Children in Columbus, MS; Paralyzed Veterans of America; Patient Access Coalition; Patient Access to Responsible Care Alliance; Pediatric Orthopedic Society of North America; Pennsylvania Council of Children in Harrisburg, PA; Personal & Family Counseling Service of New Philadelphia, OH; Philadelphia Health Management Corporation in PA; Planned Parenthood Federation of America; Presbyterian Home for Children; Provident Counseling, Inc. in St. Louis, MO; Rehabilitation Engineering and Assistive Technology Society of North America; Religious Action Center of Reform Judaism; Research Institute for Independent Living; Riverbend Head Start & Family Service; Salem Children's Home; Salvation Army Family Services; San Mar, Inc. of Boonsboro, MD; Scarsdale Edgemont Family Counsel in NY; School Social Work Association of America.

Seattle Children's Home in WA; Seedco/Non-Profit Assistance; Service Net. Inc. in PA; Sheriffs Youth Programs of Minneapolis; Sipe's Orchard Home in Conover, NC; Sjogren's Syndrome Foundation; Society for Excellence in Eye care; Society for Women's Health Research; Society of Cardiovascular & Interventional Radiology; Society of Excellence in Eye Care; Society of Gynecologic Oncologists; Society of Maternal-Fetal Medicine; Southmountain Children's Homes of America; St. Anne Institute of Albany, NY; St. Colman's Home in Watervliet, NY; St. Joseph Children's Home; St. Joseph's Indian School in SD; St. Mary's Home Home of Beaverton, OR; St. Vincent's Services, Inc. of

Brooklyn, NY; Starr Commonwealth; Sunbeam Family Services of Oklahoma City, OK; Sunny Ridge Family Center.

Tabor Children's Services, Inc. of Doylestown, PA; Teen Rancyh, Inc. Marlette, MI; Texas Association of Leaders in Children & Family; Texas Medical Association; The Arc of the United States; The Bradley Center in PA; The Center for Families, Inc.—Shreveport, LA; The Endocrine Society; The Family Center; The Hutton Settlement in WA; The Learning Disabilities of America; The Mechanicsburg Children's Hoe of Mechanicsburg, PA; The Mill; The Omaha Home for Boys in NE; The Organization of Specialists in Emergency Medicine; The Paget Foundation for Pagets's Disease of Bone and Related Disorders; The Pressley Ridge Schools in PA; The Village Family Service Center in Fargo, ND; The Woodlands in Newark, OH; Third Way Center; Thornwell Home and School for Children in SC; Title II Community AIDS National Network.

Tourette Syndrome; Tourette Syndrome Association; Treatment Access Expansion Project; Triangle Family Services in Raleigh, NC; Tulsa Boys' Home in Tulsa, OK; Turning Point Center; Uhlich Children's Home; United Cerebral Palsy Association; United Community & Family Service; United Methodist Children's Home; United Ostomy Association; United Methodists Children's Home; US Public Interest Research Group; Vera Lloyd Presbyterian Home & Family Services in AR; Vera Lloyd Presbyterian Home; Verdugo Mental Health Center; Village for Families & Children; Virginia Home for Boys; Webster-Cantrell Hall; Whaley Children's Center; Wisconsin Association of Family and Children; Wisconsin Paralyzed Veterans of America; Woodland Hills in Duluth, MN; Yellowstone Boys and Girls Ranch in Billings, MT; Youth Haven, Inc.; Youth Service Bureau; and YWCA of Northeast Louisiana.

Mrs. FEINSTEIN. Mr. President, I rise today in support of the Bipartisan Patient Protection Act of 2001. Put simply, I believe this is a good bill.

If the Senate approves this bill, we could offer health care protections to all 190 million Americans in private health plans within a week. It's that simple.

Congress has a duty to pass a comprehensive Patients' Bill of Rights to make HMOs accountable to patients, and to ensure less HMO interference with medical decision making. We need to ensure, for example, access to emergency rooms, specialists, and clinical trials. Patients should be able to go to the emergency room closest to their home in the event of a medical emergency. This bill does just that.

Each day, 10,000 physicians see patients harmed because a health plan has refused services. Patients and doctors feel that getting quality care is a constant battle. It is time for this to stop. And the time is now.

Each day we wait to approve a comprehensive Patients' Bill of Rights, 35,000 patients are denied access to the speciality care they need to manage or diagnose their illness.

I want to read to you a heart-wrenching letter I received from a California mother who has had difficultly getting her health plan to approve medically necessary services for her disabled daughter.

I believe this letter really highlights the humane reasons Congress must enact a strong Patients' Bill of Rights this year. This mother writes:

My daughter is a total-care patient. She was in a terrible car accident approximately 14 years ago and sustained brain stem injuries and is a quadriplegic. I chose to keep her at home. Her licensed care coverage is to be 24-hour care. In the past two years, her insurance company has unilaterally cut back on her nursing care to 5.5 hours a day.

This is one of many unilateral decisions the insurance provider has made regarding her care—disregarding her doctor's and other medical providers' assessments.

I, as her mother and conservator, who is not trained in medical practices or care, am expected to cover the remainder of the 18.5 hours a day. This has caused me to quit my job, file bankruptcy, and most importantly, it has seriously affected my health.

I am a senior citizen and am not supposed to lift, however, because of the practices of the insurance company, I have no choice. I cannot tell you when I last had a full night's sleep in the past several years.

The insurance company not only cut back on her nursing care, they stopped approving her therapy which included physical, speech, and occupational.

I received a letter from her current insurance carrier stating that she was considered to be a normal employee and in August of 2001 all the aforementioned items would be stopped.

This is not based on my daughter's current doctor's orders nor her needs. This is not based on an assessment from an independent medical establishment or by an experienced, licensed nurse that was selected by the insurance company for a complete assessment which supported the necessity of 24-hour nursing care.

This decision is being made unilaterally by the insurance company officials. Is this what insurance companies can do to critically ill patients without any accountability or liability on their part?

I commend this mother for her commitment to providing her daughter with the best care available.

This letter highlights the importance of giving doctors the power to make medical decisions about coverage and care rather than the ''green eye shade'' of the insurance companies.

I strongly believe that doctors should be making the medical decisions. This bill includes several provisions to help physicians determine what is medically necessary and to prevent insurance plans from defining medical necessity.

These provisions are necessary because doctor after doctor has told me their ''horror stories'' of how plans try to arm twist, coerce, countermand, interfere with and even deny treatments that they have determined are medically necessary and appropriate.

The bill prohibits plans from punishing providers for advising patients about their options for medical treatment.

The bill also establishes, as the standard for review, that decisions should be made based on the medical condition of the patient and valid, relevant scientific evidence and clinical evidence and expert opinion.

It also requires internal and external reviews of appeals of medical necessity to be made by physicians with expertise in the area of medicine being appealed.

It requires reviewers in the independent review process to be a physician or health care professional who is licensed and ''typically treats the condition, makes the diagnosis, or provides the type of treatment under review.''

On prescription drugs, the bill requires plans to make exceptions to restrictive drug formularies for medical necessity, if prescribed by the treating physician.

It is my hope that these provisions will give doctors and other providers the legal underpinnings they need to make the professional medical judgments they are trained to make in their effort to give patients the best care possible.

I also want to briefly speak to two other very important provisions included in this bill: First, this bill provides coverage to all 190 Americans in private health plans. The competing bill in the Senate (Frist-Breaux) excludes approximately 20 million Americans because they are enrolled in a self-insured State and local government health plans. It is important we pass a bill that provides protections to all Americans.

Second, I believe this bill offers a responsible approach to liability.

Today, patients have few opportunities for recourse against the health plans that harm them. This is wrong.

This bill gets rid of a health plan's special privileges. A health plan would bear responsibility only if it makes a medical decision and the patient dies or is harmed as a result.

Doctors and other health practitioners are already held accountable for their mistakes under State law. If a ''green eye-shade'' overrules a doctor's medical judgement and harms a patient, the plan too should be held responsible.

At the same time, this bill protects employers. If an employer does not make medical decisions, the employer can't be held liable. It is that simple.

This bill does not overturn or preempt existing State liability laws. It specifically exempts doctors and hospitals from new causes of action. These are reasonable provisions. In States like California that have strong patient protections there has not been an explosion of lawsuits.

In fact, since the inception of California's right-to-sue law in January 2001 and the unlimited damage it provides for, there has not been a single lawsuit filed.

Instead, HMOs appear to be deferring more to patients' requests for treatment, according to the first data to emerge from the State's HMO regulator.

California has the longest history in managed care and the highest number of insured people in HMOs nationwide. Over 70 percent of Californians are enrolled in either a commercial HMO or a preferred provider organization, PPO. Approximately 20 million non-elderly Californians have access to health insurance through their job or privately purchase coverage.

So for California, these protections are critical.

Due in part to the high penetration of managed care, California's health care system is on the verge of collapse. Resources are stretched to the limit and patients, as a result, are not getting the services they need.

For example, California's capitation rate, the rate paid to doctors for treatment, is one of the lowest in the Nation. The average capitation rate in California reached its peak in 1993 at $45 per month. Last year, the rate dropped to $29 (PriceWaterhouse Coopers).

These low reimbursement rates undoubtedly impact quality of care and access to services.

Many California hospitals and other health care providers have been forced to limit hours of operation and discontinue services. The burden to provide care is put on those that have remained open, and many of these facilities are now facing financial problems of their own.

I know that California's health care system is not unlike other systems across the country. The bottom line is that patients should not be the one's made to suffer at the hands of a failing health care system.

People pay monthly premiums. They expect their health insurance to be there when they need it. That is what insurance is. It insures against loss from an unforeseen illness or injury.

But with HMOs today, the certainty of good health care is being seriously eroded. Many people feel that every time they need care, it is a tremendous hassle.

The bottom line is that people feel they have to fight to get the quality care they have paid for. Americans are tired of jumping through hoops to get good care.

People should not have to fight for their health care. They pay for it out of their monthly paycheck. It should be there for them when they need it.

I would like to close with a very tragic story about a young, 16 year old girl from Irvine, California who did not get the care she needed from her HMO in a timely manner. I think her story provides a poignant summary of the problem with managed care providers. Unfortunately, her story does not have a happy ending.

Serenity Silen was diagnosed with acute myeloid leukemia, or AML, in late February 1998. She had gone to her HMO four times, to four different HMO doctors, since the beginning of 1998. Each time she complained of the exact same symptoms, all of which could indicate leukemia.

Over the course of the four visits, Serenity's condition was never diagnosed. Finally, in the middle of February 1998, Serenity was taken to the emergency room of an out-of-network hospital because her mother was so frustrated with the care at their HMO.

The emergency room doctor was the first doctor, in the five weeks since the symptoms arose, to order a complete blood count test. The blood count test indicated a dangerously high white blood cell count that was symptomatic of leukemia. With a much delayed diagnosis, Serenity's leukemia was now going to be much more difficult to treat.

Fed up with the HMO, Serenity's parents sought a second opinion from a highly recognized oncologist at an out-of-network hospital. Serenity was transferred to that hospital to be under the oncologist's care. After being at the new hospital only a few days, Serenity explained to her parents that she did not realize how much pain she was in until the new hospital helped to take it away. After 2½ months at the new hospital, Serenity died. The disease had not been diagnosed in time.

I urge my colleagues to support this bill. Support this bill for the children like Serenity in your State. The constituents who battle with their HMOs daily to get the quality care they need and deserve. Many of these patients are too sick to fight with their HMOs to get access to the services necessary to treat their illnesses. How many more lives are we going to have to lose to the HMO battle before Congress wises up and passes a Patients' Bill of Rights that protects the patient?

This bill has been a long time in the making. Let's get it done this session.

## ADJOURNMENT OF THE TWO HOUSES OVER THE FOURTH OF JULY HOLIDAY

Mr. REID. Mr. President, I have a unanimous consent request that the Senate proceed to H. Con. Res. 176, the adjournment resolution, which is at the desk.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (H. Con. Res. 176) providing for conditional adjournment of the House of Representatives and a conditional recess or adjournment of the Senate.

Mr. REID. Mr. President, I ask unanimous consent that the resolution be agreed to and the motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The concurrent resolution (H. Con. Res. 176) was agreed to, as follows:

H. CON. RES. 176

*Resolved by the House of Representatives (the Senate concurring)*, That when the House adjourns on the legislative day of Thursday, June 28, 2001, or Friday, June 29, 2001, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand adjourned until 2 p.m. on Tuesday, July 10, 2001, or until noon on the second day after Members are notified to reassemble pursuant to section 2 of this concurrent resolution, whichever occurs first; and that when the Senate recesses or adjourns at the close of business on Thursday, June 28, 2001, Friday, June 29, 2001, Saturday, June 30, 2001, Monday, July 2, 2001, Tuesday, July 3, 2001, Thursday, July 5, 2001, Friday, July 6, 2001, or Saturday, July 7, 2001, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand recessed or adjourned until noon on Monday, July 9, 2001, or until such time on that day as may be specified by its Majority Leader or his designee in the motion to recess or adjourn, or until noon on the second day after Members are notified to reassemble pursuant to section 2 of this concurrent resolution, whichever occurs first.

SEC. 2. The Speaker of the House and the Majority Leader of the Senate, acting jointly after consultation with the Minority Leader of the House and the Minority Leader of the Senate, shall notify the Members of the House and the Senate, respectively, to reassemble whenever, in their opinion, the public interest shall warrant it.

Mr. REID. Mr. President, for the edification of Members, the resolution allows the House to go out today or tomorrow and allows the Senate to go out any day up until July 7.

## MORNING BUSINESS

Mr. REID. Mr. President, I ask unanimous consent that there now be a period for morning business, with Senators permitted to speak for up to 5 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

## HONORING NEW YORK FIREFIGHTERS—JOHN J. DOWNING, BRIAN FAHEY, AND HARRY FORD, WHO LOST THEIR LIVES IN THE LINE OF DUTY

Mrs. CLINTON. Mr. President, let me state for the RECORD that the request I am about to make has been cleared on the Republican side.

I ask unanimous consent that the Judiciary Committee be discharged from further consideration of S. Res. 117 and that the Senate then proceed to its immediate consideration.

The PRESIDING OFFICER. The clerk will state the resolution by title.

The assistant legislative clerk read as follows:

A resolution (S. Res. 117) honoring John J. Downing, Brian Fahey, and Harry Ford, who lost their lives in the course of duty as firefighters.

There being no objection, the Senate proceeded to consider the resolution.

Mrs. CLINTON. Mr. President, I rise today to introduce a resolution honoring John J. Downing, Brian Fahey, and Harry Ford, who gave their lives this past Father's Day while protecting the lives of others. Together, these brave men left behind three widows and eight children whom we also honor today for their sacrifice.

On June 17, as a treacherous five-alarm fire raged at the Long Island General Supply Company in Queens, NY, without hesitation, as they have done countless times before, nearly 350 firefighters and numerous police officers responded to the call for help. Two civilians and dozens of firefighters and police officers were injured. And three courageous fathers lost their lives. It

was the last time their children would be able to spend Father's Day with them.

John Downing was 40 years old, an 11-year veteran of the New York Fire Department when he responded to the five-alarm blaze. He was a valiant public servant who had been recognized for his bravery. John left behind his wife Anne, his 7-year-old daughter Joanne, and his three-year-old son Michael.

Brian Fahey, 46 years old, and a 14-year veteran of the department from East Rockaway, NY, was also a husband and father of three. His years of service to his community were made proud by his courage. He is survived by his wife Mary and their three sons: Brendan, 8; and twins, Patrick and James, 3½ years old.

Harry Ford, age 50, gave nearly three decades of service to the New York City Fire Department. During his exemplary career, he received nine bravery citations. He is survived by his wife Denise; his daughter Janna O'Brien, age 24; and two sons, Harry, 12, and Gerard, 10.

Mr. President, I paid a call on the two firehouses early Sunday morning who had lost these brave compatriots, and I spent time talking to the men who go to work every day not knowing what is going to be asked of them, who sometimes go for, thankfully, days, or weeks, or months, and even years without ever having to put themselves in danger. But when the call comes, they are ready. And whether it is a call to respond to an emergency need because of an illness, an accident, or a huge raging fire that is about to get out of control, they represent the very best we have in our society.

We live in a society that seems to be in perpetual search for heroes, whether in the form of sports figures or screen idols. But to find true heroes, sometimes we don't have to look so very far from home. We certainly don't have to look any farther than the brave men we are honoring today.

The unmistakable courage and the incalculable sacrifices that they and their families have made for the good of their neighbors and their community are the kinds of virtues and values that should be held up to our children and ourselves as something we should all aspire to.

Finally, in so honoring these men, we honor the hundreds of thousands of public safety officers across this country that, every single day, risk their lives and put them and their families at risk to keep us safe from harm. Their strong tradition of bravery and sacrifice keeps our communities safe and fills our hearts with pride for their selfless acts of courage for others.

I hope that next year when Father's Day comes around, the children who have lost their fathers in this fire and those who have lost fathers and mothers because they were serving us will know how grateful we are for their sacrifice. I hope all of my colleagues will join me in supporting this resolution.

I yield back the remainder of my time.

Mr. DODD. Mr. President, I rise in support of Senator CLINTON's resolution honoring the fallen firefighters of New York and to join with her in acknowledging the bravery and commitment of Harry Ford, Brian Fahey, and John Downing. These men were firefighters—firefighters who risked their lives and gave their lives to protect the public. These men died on Sunday, June 17th, while fighting a fire in Queens, New York. The price they paid on our behalf was as great a price as any citizen can pay. We owe these men our deepest appreciation and respect.

On Sunday, the 17th—Father's Day—Firefighters Ford, Fahey and Downing worked quickly to fight a fire in a local hardware store. Thirty minutes after leaving the fire station, responding to what they thought was a routine call, an explosion buried the men under a pile of rubble. Dozens of firefighters worked to rescue the men, but they could not be reached in time.

These men were husbands and fathers. Harry Ford leaves behind his wife, Denise and two sons, Harry, age 12, and Gerard, age 10. Brian Fahey leaves us with his wife, Mary and three sons: Brendan, who is 8 years old, and 3-year-old twins, Patrick and James. John Downing is survived by his wife Anne, his daughter Joanne, age 7, and his son Michael, who is 3. My thoughts and prayers are with these families.

I am humbled by their devotion to public service. Their deaths represent the ultimate sacrifice a person can make for his or her fellow human beings. They died while fighting a fire and it is not hyperbole to say that they died while making America a safer place to live.

I am always saddened to realize that it takes a tragedy like this to bring attention to the needs of fire departments and firefighters nationwide. I hope that the memory of these three men will help Americans realize the impact of firefighters on our daily lives.

Firefighters are almost always the first in a community to respond to a call for help. They are on the scene of traffic accidents and construction accidents. When a natural or man-made calamity strikes—from hurricanes to school shootings to bombings—firefighters are there without fail, restoring order and saving lives.

Unfortunately, fire departments across the Nation struggle to find resources to help keep our communities safe. As the demands placed on fire departments have grown in volume and magnitude, the ability of local residents to support them has been put to a severe test. As a result, towns and cities throughout the country are struggling mightily to provide the fire departments with the resources they require.

For these reasons I have strongly supported helping localities meet their critical objectives. Communities need more firefighters and community firefighters need the resources to ensure that they have the training and equipment to protect themselves and the public.

Last year we passed an important piece of legislation called the Firefighter Investment and Response Enhancement Act which authorized the Federal Emergency Management Agency to provide grants to local firefighters so they could purchase the equipment they need. Congress appropriated $100 for the program last year and the FEMA has just completed the first grant competition under the program. The demand is extraordinary. FEMA received nearly $3 billion worth of grant applications—that's 30 times more in requests that is currently available.

No amount of funding can bring back Firefighters Ford, Fahey, and Downing. New fire trucks or better training programs or even more firefighters cannot even begin to compensate for the loss suffered by the people of Queens and the families of these brave men. For their lives, we are forever indebted. But for their cause, we can dedicate ourselves to help ensure that no firefighter ever enters a burning building without the best possible training and equipment.

So I stand here before you, Mr. President, and the members of this chamber to say that these men and their families shall not be forgotten. They have sacrificed their lives for us, and for this they deserve no less than the highest degree of honor and respect. We here today cannot compare our own deeds to those of Harry Ford, Brian Fahey, and John Downing, but we can bring honor to ourselves and justice to their memories by keeping them and the needs of the fire service in mind as we perform our own duties.

Mrs. CLINTON. Mr. President, I ask unanimous consent that the resolution and preamble be agreed to en bloc, and the motion to reconsider be laid upon the table.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 117) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 117

Whereas on June 17, 2001, 350 firefighters and numerous police officers responded to a 911 call that sent them to Long Island General Supply Company in Queens, New York;

Whereas a fire and an explosion in a 2-story building had turned the 128-year-old, family-owned store into a heap of broken bricks, twisted metal, and shattered glass;

Whereas all those who responded to the scene served without reservation and with their personal safety on the line;

Whereas 2 civilians and dozens of firefighters were injured by the blaze, including firefighters Joseph Vosilla and Brendan Manning who were severely injured;

Whereas John J. Downing of Ladder Company 163, an 11-year veteran of the department and resident of Port Jefferson Station, and a husband and father of 2, lost his life in the fire;

Whereas Brian Fahey of Rescue Company 4, a 14-year veteran of the department and resident of East Rockaway, and a husband and father of 3, lost his life in the fire; and

Whereas Harry Ford of Rescue Company 4, a 27-year veteran of the department from Long Beach, and a husband and father of 3, lost his life in the fire: Now, therefore, be it

*Resolved*, That the Senate—

(1) honors John J. Downing, Brian Fahey, and Harry Ford, who lost their lives in the course of duty as firefighters, and recognizes them for their bravery and sacrifice;

(2) extends its deepest sympathies to the families of these 3 brave heroes; and

(3) pledges its support and to continue to work on behalf of all of the Nation's firefighters who risk their lives every day to ensure the safety of all Americans.

## A CALL FOR ACTION

Mr. LEVIN. Mr. President, a new poll conducted by the Opinion Research Corporation International and released by the Brady Campaign to Prevent Gun Violence confirms once again that the American people support sensible gun safety legislation. Eighty-three percent of those polled said they support criminal background checks on all gun purchases at gun shows. Nearly four out of five respondents voiced support for preventing gun dealers from selling guns to anyone who has not passed a background check, even if it takes more than 3 days to complete the check. And more than 8 out of every 10 people polled believe that all guns should be sold with childproof safety locks.

The message here is clear. People are fed up with the reports of gun violence that dominate the front page and the evening news. America wants action.

The Brady Campaign's poll and countless other studies demonstrate our mandate. The incidents of gun violence that plague our neighborhoods and endanger our children confirm our moral obligation.

We should ignore neither. We cannot let another Congress go by without action. Let's close the loopholes in our gun laws and remember the 107th Congress as a time when we made America a safer place for our children and our grandchildren.

## GENERAL ACCOUNTING OFFICE REPORT ON DISADVANTAGED BUSINESS ENTERPRISES PROGRAM

Mr. MCCONNELL. Mr. President, when the 105th Congress passed the Transportation Equity Act for the 21st Century, TEA–21, there was a vigorous and close debate about whether to convert the Disadvantaged Business Enterprise Program into a race neutral program helping all small disadvantaged businesses. It troubled many members of both Houses that we lacked basic information about the characteristics of DBEs and non-DBEs and about alleged discrimination in the transportation industry. Consequently, I introduced, with widespread bi-partisan support, an amendment to TEA–21, requiring the GAO to gather the information Congress was missing that is essential to understanding the DBE program. As Congressman SHUSTER, Chair of the House Committee on Transportation and Infrastructure and the floor manager for the transportation bill, emphasized during the House debate, the Act ''also requires a GAO study that would examine whether there is continued evidence of discrimination against small business owned and controlled by socially and economically disadvantaged individuals. I believe such a study will lay the groundwork for future reform.''

Three years later, the GAO has produced a comprehensive report on the questions Congress asked it to investigate. This objective, impartial report entitled, ''Disadvantaged Business Enterprises: Critical Information is needed to Understand Program Impact,'' GAO Report GAO–01–586, June 2001, is highly significant to the continuing legislative and judicial debate over the DBE program. Professor George R. La Noue, one of the distinguished scholars in this field, has analyzed the GAO's report. He notes that the ''DBE program has been continuously subject to litigation during its almost two decades of existence.'' Professor La Noue concludes that ''the picture of the DBE program that emerges from the GAO report is one of essential information that is missing, or if available, does not support any finding of a national pattern of discrimination against DBEs.'' I am pleased to provide Professor La Noue's analysis of the GAO report, and I request that it be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

AN ANALYSIS OF ''DISADVANTAGED BUSINESS ENTERPRISES: CRITICAL INFORMATION IS NEEDED TO UNDERSTAND PROGRAM IMPACT''

GAO Report [GAO–01–586 June 2001]

(By George R. La Noue, Professor of Political Science)

DIRECTOR, PROJECT ON CIVIL RIGHTS AND PUBLIC CONTRACTS, UNIVERSITY OF MARYLAND, BALTIMORE COUNTY

During the 1998 consideration of the Transportation Equity Act for the 21st Century (TEA–21), there was extensive debate in both Houses about whether to make the DBE program race-neutral. In the end, a compromise was reached to retain a race conscious DBE program, while requiring the General Accounting Office to make a three year study of the characteristics of the DBEs and non-DBEs participating in federal transportation programs and to gather existing evidence of discrimination against DBEs. Such information was intended to provide a solid basis of facts for courts, legislators, and others grappling with the complex issues of the constitutionality of the DBE program.

The GAO study now has been released and its conclusions are highly significant. GAO performed its three year study by obtaining data from 52 state DOT recipients (including the District of Columbia and Puerto Rico) and 31 of the largest (accounting for two-thirds of transit grant funds obligated in 1999) transportation districts in the country. In addition GAO staff interviewed representatives of interest groups on both sides of the DBE question and analyzed the results of 14 transportation related disparity studies.

Following are GAO's major conclusions.

1. DISCRIMINATION COMPLAINTS

GAO conducted a survey of discrimination complaints received by USDOT and recipients. GAO found that, while USDOT sometimes receives written complaints of discrimination, the agency does not compile or analyze the information in those complaints. GAO could not supply information on the number of complaints filed, investigations launched, or their outcomes. (p. 33) GAO also asked state and local transit recipients about complaints they received and they had better data. During 1999 and 2000, 81 percent of the recipients had no complaints, while a total of 31 complaints were received by the other recipients. Of these, 29 were investigated and findings of discrimination were made only 4 times across the nation .

The report concluded: Other factors may also limit the ability of DBEs to compete for USDOT-state assisted contracts. The majority of states and transit districts we surveyed had not conducted any kind of analysis to identify these factors. Using anecdotal information, we identified a number of factors, or barriers, such as a lack of working capital and limited access to bonding, that may limit DBEs' ability to compete for contracts. However, there was little agreement among the officials we contacted on whether these factors were attributable to discrimination. (p.7)

In fact GAO reported there were few if any studies by government agencies or industry groups regarding barriers to DBE contracting. ''USDOT officials, however, stated that they believe contract bundling is one of the largest barriers for DBEs in competing for transportation contracts.'' (p. 35) That, of course, is not a problem caused by discrimination.

2. DISPARITY STUDIES

GAO also reviewed 14 transportation-specific disparity studies completed between 1996 and 2000. GAO examined these studies because they might be a source of evidence about discrimination against DBEs and because USDOT permits recipients to use disparity studies to set annual goals and to determine the level of discrimination these goals purportedly are remedying. GAO found that about 30 percent of the recipients surveyed used disparity studies to set their fy 2000 goals. (p. 29).

GAO found that: the limited data used to calculate disparities, compounded by the methodological weaknesses, create uncertainties about the studies findings. . . . While not all studies suffered from every problem, each suffered enough problems to make its findings questionable. We recognize there are difficulties inherent in conducting disparity studies and that such limitations are common to social science research; however, the studies we reviewed did not sufficiently address such problems or disclose their limitations. (p.29)

GAO then detailed disparity study problems, particularly in calculating DBE availability. These problems are important not only because they undermine the validity of the disparity studies involved, but because these same problems exist in the regulations USDOT issued regarding annual goal setting. USDOT as a practical matter permits recipients to use a wide variety of sources to measure availability on which goals are then based.

GAO made other specific criticisms of the studies. For example, the studies did not have information on firm qualifications or capacities; they failed to analyze both the dollars and contracts awarded and sometimes did not have subcontracting data. This

was important: Because MBE/WBEs are more likely to be awarded subcontracts than prime contracts, MBEs/WBEs may appear to be underutilized when the focus remains on prime contractor data. Furthermore, although some studies did include calculations based on the number of contracts, all but two based their determination of disparities on only the dollar amounts of the contracts. Because MBEs/WBEs tend to be smaller than non-MBEs/WBEs, they often are unable to perform on larger contracts. Therefore, it would appear that they were awarded a disproportionately smaller amount of contract dollars. (p. 32) (see data on contracting awards on p. 51)

GAO's conclusion here is significant because the USDOT regulations measure utilization only in dollars, not contracts, and annual goals are set based on total dollars rather than on the DBE share of subcontracting dollars.

Finally GAO notes that although USDOT advised recipients that disparity studies should be ''reliable,'' USDOT provided no guidance on what would be a reliable study. GAO concluded that: USDOT's guidance does not, for example, caution against using studies that contain the types of data and methodological problems that we identified above. Without explicit guidance on what makes a disparity study reliable, states and transit authorities risk using studies that may not provide accurate information in setting DBE goals. (p. 32)

GAO's finding about the unreliability of disparity studies is consistent with the findings of every court that has examined the merits of such studies after discovery and trial.

3. DISCONTINUING PROGRAMS

One of the arguments used in the TEA–21 debates and defendant's trial briefs is the assertion, often anecdotal, that without goals, DBE participation would decline precipitously. The difficulty with that assertion, even if true, is that the decline in DBE participation may be the result of previous overutilization caused by goals set too high or because when a program is struck down DBEs may have little incentive to seek or maintain certification.

But is the basic assertion true? It turned out that 10 of 12 recipients with discontinued programs did not know what the DBE participation result was. For instance, although Michigan was cited by DBE proponents in the TEA–21 debate as an example of DBE utilization decline after Michigan Road Builders Assn. v. Millikin (1987) struck down the state highway MBE program, GAO reports: Michigan could not provide us with minority and women owned business participation data in state highway contracting for the years immediately before and after it discontinued its program. Furthermore, Michigan officials stated that the analysis showing the decline that is often cited was a one-time-only analysis and that analysis is no longer available. Consequently we can not verify the number cited during the debate (p.37)

4. MISSING INFORMATION

Much of the above criticisms GAO cast in terms of a lack of information, but there were other key items missing as well. GAO had planned to survey all transit authorities receiving federal funds, but FTA does not have a complete list. (p. 74) When the 83 state and transit recipients were surveyed, only 40% or less of the respondents could report the gross revenues of the DBEs that won contracts. Less than 25% of the respondents could report the gross revenues of the DBEs that did not win contracts. (pp. 52–55) Only about a third of the agencies could report data on the personal net worth of DBE owners, although TEA–21 regulations require that such owners net worth not exceed $750,000.

Only a handful of respondents could report data on the gross revenues or owner net worth characteristics of non-DBE firms. (p. 64) While 79 respondents could report data about subcontracts awarded DBEs, only 28 respondents could report similar data for non-DBEs. That means that most respondents did not regard comparing DBE and non-DBE subcontractor utilization relevant in setting goals or in determining whether discrimination exists.

Nor are respondents acquiring relevant information: 98.8% have not conducted any study determining if awarding prime or sub contracts to DBEs affects contract costs; 67.5% no study on discrimination against DBE firms; 84.2% no study of discrimination against DBEs by financial credit, insurance or bond markets; 79.5% no study of factors making it difficult for DBEs to compete; and 92.8% no study on the impact of the DBE program on competition and the creation of jobs. (pp. 66–68). Only 26.5% of the respondents have developed and implemented use of a bidders list, although the regulations require such.

The DBE program has been continuously subject to litigation during its almost two decades of existence. Overall, the picture of the DBE program that emerges from the GAO report is one of essential information that is missing, or if available, does not support any finding of a national pattern of discrimination against DBEs.

## LOCAL LAW ENFORCEMENT ACT OF 2001

Mr. SMITH of Oregon. Mr. President, I rise today to speak about hate crimes legislation I introduced with Senator KENNEDY in March of this year. The Local Law Enforcement Act of 2001 would add new categories to current hate crimes legislation sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred April 18, 1998 in New York City. A man who used anti-gay epithets allegedly slashed a gay man in the face with a knife. Eric Rodriguez, 22, was charged with attempted murder, assault, and criminal possession of a weapon.

I believe that government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act of 2001 is now a symbol that can become substance. I believe that by passing this legislation, we can change hearts and minds as well.

## RAILROAD CROSSING DELAY REDUCTION ACT

Mr. DURBIN. Mr. President, earlier this month I introduced the Railroad Crossing Delay Reduction Act, S. 1015, with my colleagues, Senators LEVIN and STABENOW.

This legislation would accelerate efforts at the U.S. Department of Transportation to address the issue of rail safety by requiring the Secretary of Transportation to issue specific regulations regarding trains that block automobile traffic at railroad crossings. Currently, there are no Federal limits on how long trains can block crossings. The Railroad Crossing Delay Reduction Act would simply minimize automobile traffic delay caused by trains blocking traffic at railroad grade crossings.

In northeastern Illinois, there are frequent blockages at rail crossings. These blocked crossings prevent emergency vehicles, such as fire trucks, police cars, ambulances, and other related vehicles from getting to their destinations during the times of need. This is a serious problem and one I hope to address by passage of this important legislation.

Blocked rail crossings also delay drivers by preventing them from getting to their destinations. Motorists, knowing they will have to wait for a train to move at blocked crossings, sometimes try to beat the train or ignore signals completely. This is a threat to public safety, and one that must stop. Motorists must act responsibly, but we can reduce the temptation by reducing delays.

Trains stopped for long periods of time also tempt pedestrians to cross between the train cars. I've heard from local mayors in my State that children, in order to get home from school, cross between the rail cars. This is a terrible invitation to tragedy.

Trains blocking crossings cause traffic problems, congestion, and delay. These issues are very real. They are serious. And more importantly, they are a threat to public safety. To address these problems, I've introduced with my colleagues the Railroad Crossing Delay Reduction Act. I'm hopeful this legislation will provide for a safer Illinois and a safer Nation. I urge my colleagues to join the effort to reduce blocked rail-grade crossings by cosponsoring and supporting S. 1015.

## THE VERY BAD DEBT BOXSCORE

Mr. HELMS. Mr. President, at the close of business yesterday, Wednesday, June 27, 2001, the Federal debt stood at $5,655,167,264,852.88, Five trillion, six hundred fifty-five billion, one hundred sixty-seven million, two hundred sixty-four thousand, eight hundred fifty-two dollars and eighty-eight cents.

One year ago, June 27, 2000, the Federal debt stood at $5,650,720,000,000, Five trillion, six hundred fifty billion, seven hundred twenty million.

Five years ago, June 27, 1996, the Federal debt stood at $5,118,104,000,000, Five trillion, one hundred eighteen billion, one hundred four million.

Ten years ago, June 27, 1991, the Federal debt stood at $3,502,028,000,000, Three trillion, five hundred two billion, twenty-eight million.

Fifteen years ago, June 27, 1986, the Federal debt stood at $2,040,977,000,000, Two trillion, forty billion, nine hundred seventy-seven million, which reflects a debt increase of more than $3.5 trillion, $3,614,190,264,852.88, Three trillion, six hundred fourteen billion, one hundred ninety million, two hundred

sixty-four thousand, eight hundred fifty-two dollars and eighty-eight cents during the past 15 years.

## ADDITIONAL STATEMENTS

### CONGRATULATING JAMES W. AND JESSE ANN DAVIS

● Mr. ALLEN. Mr. President, I rise today to congratulate two residents of Ashburn, Virginia, on the birth of one of my newest constituents and a fine young man, James Michael Davis. James Michael was born on March 20, 2001, weighing 6 pounds and 10 ounces, and is the proud son of James W. Davis, a member of the U.S. Capitol K–9 Police Force, and Jesse Ann Davis. He is the grandson of Edith Louise Davis and the late James Carl Davis, and Stella Canchola and the late Raymond Canchola.

James Michael has entered a world of unlimited opportunity and possibilities. His parents and grandparents will help instill virtues of independence, self-reliance, perseverance and determination, all of which will serve him well along the road of life.

I want to extend my best wishes to James Michael for many years of health and happiness.●

### IN RECOGNITION OF DR. RICHARD W. McDOWELL

● Mr. LEVIN. Mr. President, I am delighted to speak today to acknowledge a leader, from my home State of Michigan, who has dedicated his life to serving the citizens in Michigan, Dr. Richard W. McDowell. Today, many people will gather to pay tribute to Dr. McDowell for his service as President of Schoolcraft College, in Livonia, MI, for the past twenty years.

Dr. McDowell has dedicated his life, both professionally and personally, to the service of his community. Dr. McDowell has served capably and honorably as the President of Schoolcraft College during a period of incredible growth for this institution. He has presided over programs and projects that have reshaped the campus, and enhanced its ability to meet the needs of students at Schoolcraft College.

During his tenure as President, Dr. McDowell has presided over the construction of numerous structures including additions to the Campus Center, the Child Care Center and the student center that bears his name. In addition to enhancing the physical facilities, he has greatly enhanced the economic structure of the campus by forming the Schoolcraft Development Authority, and by expanding the endowment of the college. These efforts will secure the ability of the school to maintain a world-class campus while providing students with access to an affordable education.

In addition to these activities, Dr. McDowell is a leader in his profession and in numerous civic institutions. His love of academia and education translated into his desire to serve the educational community writ large. Dr. McDowell has served as President of the Michigan Community College Association, and he has been a member of the Michigan Educational Trust Board, the National Advisory Panel for the Community College Program at the University of Michigan, the American Association of Community Colleges and the North Central Association of Colleges and Schools.

He has further assisted his community by serving on the board of Wayne County Private Industry Corporation, St. Mary Mercy Hospital and the City of Livonia Ethics Board. This selfless leadership has been recognized by many organizations, including his alma maters—Indiana University of Pennsylvania and Purdue University. Both of these institutions awarded him their distinguished alumni awards. In addition, he was selected one of the top fifty community college presidents in the United States by the Community College Leadership Program at the University of Texas at Austin.

I hope my Senate colleagues will join me in saluting Dr. McDowell for his career of public service, particularly the commitment to education which he has exhibited for the last two decades.●

### CONCRETE CANOE COMPETITION

● Mr. SESSIONS. Mr. President, I join with my colleagues in support of the Concrete Canoe Competition.

Civil Engineers design the backbone of our Nation's infrastructure. By designing, building, and maintaining our infrastructure, these engineers have quietly helped to shape the history of our Nation and its communities. Civil Engineers contribute daily to our standard of living through their designing, building, and maintaining our transportation, clean water, and power generation systems.

A great example of civil engineering ingenuity is manifested through the National Concrete Canoe Competition. The Concrete Canoe Competition provides college and university students an opportunity to use the engineering principles learned in the classroom, and apply them in a competitive environment where they further learn important team and project management skills.

I am very pleased to announce that on June 16, 2001, the University of Alabama at Huntsville won an unprecedented fifth national Championship in the Concrete Canoe Competition.●

### RETIREMENT OF JOHN C. HOY AS PRESIDENT OF THE NEW ENGLAND BOARD OF HIGHER EDUCATION

● Mr. KENNEDY. Mr. President, it is an honor today to recognize the outstanding accomplishments of John C. Hoy, president of the New England Board of Higher Education, who is retiring this month. Mr. Hoy has dedicated the past twenty-three years to serving the higher education institutions of New England, and his leadership will be greatly missed.

Since he became president of the Board in 1978, Mr. Hoy has led the effort to provide an accessible and affordable education for every New Englander. To accomplish this goal, he established reforms in his own organization, and he also involved individuals and businesses throughout New England in effective partnerships that served students and institutions alike.

Among his primary achievements was the publication of numerous important books, including studies on the relationship between higher education and economic well-being in New England, the links between U.S. competitiveness and international aspects of higher education, and the effects of legal education on the New England economy.

In addition, John Hoy offered much-needed support to minority communities. He encouraged greater participation by Blacks and Hispanics in higher education, and he worked effectively to increase the number of ethnic minorities completing PhD programs. He also created a scholarship program for Black South African students at South Africa's open universities under apartheid.

John Hoy also cared deeply about the way technology was changing higher education, in New England and around the country. Under his initiative, the Board explored the promise of biotech industries and manufacturing in New England, and worked to improve technical education, with the help of both professional educators and the private sector. In addition, he worked with other regional boards of higher education to coordinate telecommunications among higher educational institutions.

John C. Hoy deserves great credit for all he has done to enhance higher education in New England. His accomplishments are deeply appreciated by all of us who know him, and I welcome this opportunity to wish him a long and happy retirement.●

### HONORING DR. BERNARD MEYERS

● Mr. CRAPO. Mr. President, I rise today to say thank you to Dr. Bernard ''Bernie'' Meyers, President and General Manager of Bechtel BWXT Idaho, LLC (BBWI). BBWI manages the Idaho National Engineering and Environmental Laboratory (INEEL) for the United States Department of Energy.

The INEEL is the third largest employer in the state of Idaho and the largest employer in my hometown of Idaho Falls. For the past 2 years Bernie's professional and personal skills have helped lead the INEEL in its mission to be an enduring national resource that delivers science and engineered solutions to the world's environmental, energy and security challenges.

On August 1, 2001, Bernie will retire as President of BBWI and assume additional duties on behalf of Bechtel. In addition to his duties as President of BBWI, Bernie is also Senior Vice President in the 30,000 employee worldwide Bechtel organization.

Bernie's 39-year professional career includes 26 years spent with Bechtel, where he has risen through the nuclear engineering ranks while serving as an Engineer, Supervisor, Project Manager, Vice President, and finally as Senior Vice President.

Bernie's stewardship of Bechtel BWXT Idaho represents a strong demonstration of Bechtel's commitment to provide customer satisfaction and operational excellence for the eastern Idaho community. In addition to being a Senior Vice President, Bernie has in the past directed major Bechtel companies, managed North American operations, headed up the firm's Engineering and Construction operations, managed Bechtel's nuclear business line and served as an ''in-the-trenches'' project manage for some $30 billion worth of nuclear power jobs.

During that same time, Bernie gained INEEL-applicable experience in integrating safety through diverse workforces and in serving as a leader in nuclear technologies and nuclear operations. Over the years, he has managed large, complex and highly technical entities; overseen research and development organizations, and helped expand new and existing business lines into both national and international markets. He also has integrated technical, management and business systems across multiple offices, companies, sites, and disciplines.

Bernie is a Fellow in the American Society of Civil Engineers and the American Concrete Institute, and has authored a textbook, as well as more than 60 professional papers. He holds a master's degree in civil engineering from the University of Missouri and a doctor's degree in civil engineering from Cornell University.

During his time in Idaho, Bernie Meyers has provided sound thinking, decisive leadership and an intelligent vision for the future of the INEEL. He has provided honest and frequent communications about INEEL activities with Idaho's Congressional delegation, Idaho elected officials, key stakeholders, business and community leaders and the site's employees.

Under Bernie leadership, BBWI has proven to be a solid corporate neighbor throughout the state of Idaho. His advocacy for science education has helped to firmly establish the JASON Science Education program in the state, creating an awareness of science and technology careers for Idaho's elementary and secondary school students. His support of art, cultural and civic causes have contributed to the financial well being of many of organizations in Idaho.

On behalf of the people of Idaho, I want to say thank you to Bernie Meyers for a job well done. I want to wish Bernie and his wife Rita all the best as they tackle new challenges in the years ahead.●

## WE THE PEOPLE COMPETITION

● Mr. MILLER. Mr. President, I would like to congratulate the following students for their outstanding performance in the national finals of the ''We the People . . . The Citizen and the Constitution'' contest in Washington, D.C. on April 21–23, 2001.

Joey Angel, David Connor, Darrell Davis, Eric Elloie, Jesse Gelbaum, Lindsey Green, Kyle Hale, Matthew Hall, Lisa Jones, David Lee, Jennie Long, Greer Pasmanick, Benjamin Riddick, Emily Rubinson, Matthew Snyder, Sanjay Tamhane, Jordan Tritt, and Scott Visser.

The leaders of this exceptional group of students are: Celeste Boemker, Teacher, Parker Davis, State Coordinator, and John Carr, District Coordinator.●

## MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Ms. Evans, one of his secretaries.

## EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States submitting sundry nominations where were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

## REPORT OF THE CORPORATION FOR PUBLIC BROADCASTING FOR FISCAL YEAR 2000—MESSAGE FROM THE PRESIDENT—PM 32

The PRESIDING OFFICER laid before the Senate the following message from the President of the United States, together with an accompanying report; which was referred to the Committee on Commerce, Science and Transportation.

*To the Congress of the United States:*

In accordance with the Public Broadcasting Act of 1967, as amended (47 U.S.C. 396(i)), I transmit herewith the Annual Report of the Corporation for Public Broadcasting for Fiscal Year 2000.

GEORGE W. BUSH.

THE WHITE HOUSE, *June 28, 2001.*

## REPORT ON THE COMPREHENSIVE NATIONAL ENERGY POLICY DATED JUNE 2001—MESSAGE FROM THE PRESIDENT—PM 33

The PRESIDING OFFICER laid before the Senate the following message from the President of the United States, together with an accompanying report; which was referred to the Committee on Energy and Natural Resources.

*To the Congress of the United States:*

One of the first actions I took when I became President in January was to create the National Energy Policy Development Group to examine America's energy needs and to develop a policy to put our Nation's energy future on sound footing.

I am hereby transmitting to the Congress proposals contained in the National Energy Policy report that require legislative action. In conjunction with executive actions that my Administration is already undertaking, these legislative initiatives will help address the underlying causes of the energy challenges that Americans face now and in the years to come. Energy has enormous implications for our economy, our environment, and our national security. We cannot let another year go by without addressing these issues together in a comprehensive and balanced package.

These important legislative initiatives, combined with regulatory and administrative actions, comprise a comprehensive and forward-looking plan that utilizes 21st century technology to allow us to promote conservation and diversify our energy supply. These actions will increase the quality of life of Americans by providing reliable energy and protecting the environment.

Our policy will modernize and increase conservation by ensuring that energy is used as efficiently as possible. In addition, the National Energy Policy will modernize and expand our energy infrastructure, creating a new high-tech energy delivery network that increases the reliability of our energy supply. Further, it will diversify our energy supply by encouraging renewable and alternative sources of energy as well as the latest technologies to increase environmentally friendly exploration and production of domestic energy resources.

Importantly, our energy policy improves and accelerates environmental protection. By utilizing the latest in pollution control technologies to cut harmful emissions we can integrate our desire for a cleaner environment and a sufficient supply of energy for the future. We will also strengthen America's energy security. We will do so by reducing our dependence on foreign sources of oil, and by protecting low-income Americans from soaring energy prices and supply shortages through programs like the Low Income Housing Energy Assistance Program.

My Administration stands ready to work with the Congress to enact comprehensive energy legislation this year.

GEORGE W. BUSH.

THE WHITE HOUSE, *June 28, 2001.*

## REPORT ON THE EMERGENCY REGARDING THE PROLIFERATION OF WEAPONS OF MASS DESTRUCTION—MESSAGE FROM THE PRESIDENT—PM 34

The PRESIDING OFFICER laid before the Senate the following message from the President of the United States, together with an accompanying report; which was referred to the Committee on Banking, Housing and Urban Development.

*To The Congress of the United States:*

Enclosed is a report to the Congress on Executive Order 12938, as required by section 204 of the International Emergency Economic Powers Act (50 U.S.C. 1703(c)) and section 401(c) of the National Emergencies Act (50 U.S.C. 1641(c)).

GEORGE W. BUSH.
THE WHITE HOUSE, *June 28, 2001*.

## MESSAGES FROM THE HOUSE

At 10:21 a.m., message from the House of Representatives, delivered by Mr. Hays, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 691. An act to extend the authorization of funding for child passenger protection education grants through fiscal year 2003.

H.R. 2213. An act to establish a commission for the purpose of encouraging and providing for the commemoration of the 50th anniversary of the Supreme Court decision in Brown v. Board of Education.

The message also announced that the House has agreed to the following concurrent resolution, in which it requests the concurrence of the Senate:

H. Con. Res. 176. Concurrent resolution providing for a conditional adjournment of the House of Representatives and a conditional recess or adjournment of the Senate.

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At 5:59 p.m., a message from the House of Representatives, delivered by Mr. Hays, one of its reading clerks, announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 2311. An act making appropriations for energy and water development for the fiscal year ending September 30, 2002, and for other purposes.

The message also announced that pursuant to section 201(b) of the International Religious Freedom Act of 1998 (22 U.S.C. 6431), as amended by Public Law 106–55, and upon the recommendation of the Minority Leaders, the Speaker appoints the following members on the pat of the House of Representatives to the Commission on International Religious Freedom to fill the existing vacancies thereon, for terms to expire on May 14, 2003: Ms. Leila Sadat of St. Louis, Missouri and Ms. Felice Gaer of Paramus, New Jersey.

## MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 691. An act to extend the authorization of funding for child passenger protection education grants through fiscal year 2003; to the Committee on Commerce, Science, and Transportation.

H.R. 2133. An act to establish a commission for the purpose of encouraging and providing for the commemoration of the 50th anniversary of the Supreme Court decision in Brown v. Board of Education; to the Committee on the Judiciary.

H.R. 2311. An act making appropriations for energy and water development for the fiscal year ending September 30, 2002, and for other purposes; to the Committee on Appropriations.

## ENROLLED BILL PRESENTED

The Secretary of the Senate reported that on today, June 28, 2001, he had presented to the President of the United States the following enrolled bill:

S. 657. An act to authorize funding for the National 4–H Program Centennial Initiative.

## PETITIONS AND MEMORIALS

The following petitions and memorials were laid before the Senate and were referred or ordered to lie on the table as indicated:

POM–123. A concurrent resolution adopted by the Senate of the Legislature of the State of Louisiana relative to the Interstate highway system; to the Committee on Environment and Public Works.

SENATE CONCURRENT RESOLUTION NO. 106

Whereas, safety rest areas located on the rights of way of the Interstate highway system provide necessary services for Louisiana motorists, as well as visitors to Louisiana; and

Whereas, there are currently thirty-four rest areas along interstate highways in Louisiana; and

Whereas, the annual cost of upkeep and maintenance of these rest areas is approximately three and one-half million dollars; and

Whereas, the state is required by federal law to maintain these rest areas; and

Whereas, the Louisiana Department of Transportation and Development has scheduled approximately fifteen of these rest areas for closure; and

Whereas, these rest areas scheduled for closure could remain open if private entities were charged with the responsibility of maintenance and upkeep; and

Whereas, Federal law currently prohibits privatization of safety rest areas located on the rights of way of the Interstate highway system. Therefore be it

*Resolved*, That the Legislature of Louisiana memoralizes the Congress of the United States to allow states to privatize safety rest areas located on the rights of way of the Interstate highway system. Be it further

*Resolved*, That a copy of this Resolution shall be transmitted to the secretary of the United States Senate and the clerk of the United States House of Representatives and to each member of the Louisiana delegation to the United States Congress.

## EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of committees were submitted:

Mr. LEVIN. Mr. President, for the Committee on Armed Services.

The following named officers for appointment in the United States Air Force to the grade indicted under title 10, U.S.C., section 624:

*To be major general*

Brig. Gen. Dale W. Meyerrose, 0000
Brig. Gen. Wilbert D. Pearson Jr., 0000

The following Air National Guard of the United States officers for appointment in the Reserve of the Air Force to the grades indicated under title 10, U.S.C., section 12203:

*To be brigadier general*

Col. Rex W. Tanberg Jr., 0000

The following named officers for appointment in the United States Army to the grade indicted under assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

*To be lieutenant general*

Lt. Gen. John A. Van Alstyne, 0000

The following named officers for appointment in the Reserve of the Army to the grade indicted under title 10, U.S.C., section 12203:

*To be major general*

Brig. Gen. James P. Collins, 0000

The following Army National Guard of the United States officer for appointment in the Reserve of the Army to the grade indicted under title 10, U.S.C., section 12203:

*To be major general*

Brig. Gen. Edward L. Correa Jr., 0000

The following named officer for appointment in the United States Army to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

*To be lieutenant general*

Lt. Gen. James C. Riley, 0000

The following named officer for appointment in the United States Army to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

*To be lieutenant general*

Maj. Gen. William S. Wallace, 0000

The following named officer for appointment in the United States Army to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

*To be lieutenant general*

Maj. Gen. Benjamin S. Griffin, 0000

The following named officer for appointment in the United States Army to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

*To be lieutenant general*

Lt. Gen. Leon J. LaPorte, 0000

The following named officer for appointment as Chief of the Bureau of Medicine and Surgery and Surgeon General and for appointment to grade indicted under title 10, U.S.C., sections 601 and 5137:

*To be vice admiral*

Rear Adm. Michael L. Cowan, 0000

The following named officer for appointment in the United States Navy to the grade indicted while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

*To be vice admiral*

Vice Adm. Patricia A. Tracey, 0000

The following named officer for appointment in the United States Marine Corps to the grade indicted while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

*To be vice admiral*

Maj. Gen. Edward Hanlon Jr., 0000

(The above nominations were reported with the commendation that they be confirmed.)

Mr. LEVIN. Mr. President, for the Committee on Armed Services, I report favorably the following nomination lists which were printed in the RECORDS of the dates indicated, and ask unanimous consent, to save the expense of reprinting on the Executive Calendar that these nominations lie at the Secretary's desk for the information of Senators.

The PRESIDING OFFICER. Without objection, it is so ordered.

Air Force nominations beginning STEVEN L. ADAMS and ending JANNETTE YOUNG, which nominations were received by the Senate and appeared in the Congressional Record on June 18, 2001.

Army nominations beginning KEITH S. * ALBERTSON and ending ROBERT K. ZUEHLKE, which nominations were received by the Senate and appeared in the Congressional Record on January 3, 2001.

Army nominations beginning ERIC D. * ADAMS and ending DAVID S. ZUMBRO, which nominations were received by the Senate and appeared in the Congressional Record on May 21, 2001.

Army nominations beginning GREGGORY R. CLUFF and ending STEVEN W. VINSON, which nominations were received by the Senate and appeared in the Congressional Record on May 21, 2001.

Army nominations beginning GILL P. BECK and ending MARGO D. SHERIDAN, which nominations were received by the Senate and appeared in the Congressional Record on June 5, 2001.

Army nominations beginning CYNTHIA J. ABBADINI and ending THOMAS R. * YARBER, which nominations were received by the Senate and appeared in the Congressional Record on June 5, 2001.

Army nominations beginning JAMES E. GELETA and ending GARY S. OWENS, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2001.

Army nominations beginning FLOYD E. BELL JR. and ending STEVEN N. WICKSTROM, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2001.

Army nominations beginning ROBERT E. ELLIOTT and ending PETER G. SMITH, which nominations were received by the Senate and appeared in the Congressional Record on June 18, 2001.

Army nominations beginning BRUCE M. BENNETT and ending GRANT E. ZACHARY JR., which nominations were received by the Senate and appeared in the Congressional Record on June 18, 2001.

Navy nomination of Charlie C. Biles, which was received by Senate and appeared in the Congressional Record on May 21, 2001.

Navy nominations beginning JAMES W. ADKISSON III and ending MIKE ZIMMERMAN, which nominations were received by the Senate and appeared in the Congressional Record on May 21, 2001.

Navy nominations of William J. Diehl, which was received by the Senate and appeared in the Congressional Record on June 5, 2001.

Navy nominations of Christopher M. Rodrigues, which was received by the Senate and appeared in the Congressional Record on June 12, 2001.

Navy nominations beginning ROBERT T. BANKS and ending CARL ZEIGLER, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2001.

Marine Corps nominations of Donald E. Gray Jr., which was received by the Senate and appeared in the Congressional Record on June 12, 2001.

Marine Corps nominations beginning JESSICA L. ACOSTA and ending JOSEPH J. ZWILLER, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2001.

By Mr. INOUYE for the Committee on Indian Affairs.

Neal A. McCaleb, of Oklahoma, to be an Assistant Secretary of the Interior.

(The above nomination was reported with the recommendation that it be confirmed subject to the nominee's commitment to respond to the requests to appear and testify before any duly constituted committee on the Senate.)

## INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. BINGAMAN (for himself and Mr. DOMENICI):

S. 1118. A bill to amend the Intermodal Surface Transportation Efficiency Act of 1991 to identify certain routes in New Mexico as part of the Ports-to-Plains Corridor, a high priority corridor on the National Highway System; to the Committee on Commerce, Science, and Transportation.

By Mr. LEAHY (for himself, Mr. DEWINE, Mr. DASCHLE, Mr. COCHRAN, Mrs. CARNAHAN, Ms. SNOWE, and Mr. JOHNSON):

S. 1119. A bill to require the Secretary of Defense to carry out a study of the extent to the coverage of members of the Selected Reserve of the Ready Reserve of the Armed Forces under health benefits plans and to submit a report on the study of Congress, and for other purposes; to the Committee on Armed Services.

By Mrs. BOXER (for herself and Mr. SMITH of Oregon):

S. 1120. A bill to amend the Foreign Assistance Act of 1961 to increase the authorization of appropriations for fiscal year 2002, and to authorize appropriations for fiscal year 2003, to combat HIV and AIDS, and for other purposes; to the Committee on Foreign Relations.

By Mr. KENNEDY (for himself and Mr. KERRY):

S. 1121. A bill to suspend temporarily the duty on certain R-core transformers; to the Committee on Finance.

By Mr. TORRICELLI:

S. 1122. A bill to amend the Internal Revenue Code of 1986 to provide a refundable credit against tax with respect to education and training of developmentally disabled children; to the Committee on Finance.

By Mr. FEINGOLD (for himself, Mr. CRAIG, and Mr. KOHL):

S. 1123. A bill to amend the Dairy Production Stabilization Act of 1983 to ensure that all persons who benefit from the dairy promotion and research program contribute to the cost of the program, and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

By Mr. THOMPSON:

S. 1124. A bill to amend section 13031 of the Consolidated Omnibus Budget Reconciliation Act of 1985 to provide for a user fee to cover the cost of customs inspections at express courier facilities; to the Committee on Finance.

By Mr. MCCONNELL (for himself, Mr. AKAKA, Mr. ALLARD, Mr. BAYH, Mr. BINGAMAN, Mr. CLELAND, Mr. COCHRAN, Mr. EDWARDS, Mr. FITZGERALD, Mr. FRIST, Mr. GRAHAM, Mr. HELMS, Mr. INHOFE, Mr. JEFFORDS, Mr. KENNEDY, Mr. KERRY, Mr. KOHL, Mr. KYL, Mr. LEAHY, Mr. LEVIN, Mr. REED, Mr. SMITH of Oregon, Mr. SMITH of New Hampshire, Mr. SPECTER, Mr. TORRICELLI, and Mr. WYDEN):

S. 1125. A bill to conserve global bear populations by prohibiting the importation, exportation, and interstate trade of bear viscera and items, products, or substances containing, or labeled or advertised as containing, bear viscera, and for other purposes; to the Committee on Environment and Public Works.

By Mr. BROWNBACK (for himself and Mr. ENZI):

S. 1126. A bill to facilitate the deployment of broadband telecommunications services, and for other purposes; to the Committee on Commerce, Science, and Transportation.

By Mr. BROWNBACK (for himself and Mr. ENZI):

S. 1127. A bill to stimulate the deployment of advanced telecommunications services in rural areas, and for other purposes; to the Committee on Commerce, Science, and Transportation.

By Mrs. CLINTON:

S. 1128. A bill to provide grants for FHA-insured hospitals; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. WARNER:

S. 1129. A bill to increase the rate of pay for certain offices and positions within the executive and judicial branches of the Government, respectively, and for other purposes; to the Committee on Governmental Affairs.

By Mr. CRAIG (for himself, Mrs. FEINSTEIN, and Mr. CORZINE):

S. 1130. A bill to require the Secretary of Energy to develop a plan for a magnetic fusion burning plasma experiment for the purpose of accelerating the scientific understanding and development of fusion as a long term energy source, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. LEAHY:

S. 1131. A bill to promote economically sound modernization of electric power generation capacity in the United States, to establish requirements to improve the combustion heat rate efficiency of fossil fuel-fired electric utility generating units, to reduce emissions of mercury, carbon dioxide, nitrogen, oxides, and sulfur dioxide, to require that all fossil fuel-fired electric utility generating units operating in the United States meet new sources review requirements, to promote the use of clean coal technologies, and to promote alternative energy and clean energy sources such as solar, wind, biomass, and fuel cells; to the Committee on Finance.

By Mr. CRAPO:

S. 1132. A bill to amend the Federal Food, Drug, and Cosmetic Act relating to the distribution chain of prescription drugs; to the Committee on Health, Education, Labor, and Pensions.

By Mrs. BOXER (for herself, Mrs. CARNAHAN, and Mr. BOND):

S. 1133. A bill to amend title 49, United States Code, to preserve nonstop air service to and from Ronald Reagan Washington National Airport for certain communities in case of airline bankruptcy; to the Committee on Commerce, Science, and Transportation.

By Mr. LIEBERMAN (for himself and Mr. HATCH):

S. 1134. A bill to amend the Internal Revenue Code of 1986 to modify the rules applicable to qualified small business stock; to the Committee on Finance.

By Mr. GRAHAM (for himself, Mr. CHAFEE, Mr. CONRAD, Mrs. LINCOLN, Mr. MILLER, Mr. ROCKEFELLER, Mr. BINGAMAN, Mr. KERRY, and Mr. CARPER):

S. 1135. A bill to amend title XVIII of the Social Security Act to provide comprehensive reform of the medicare program, including the provision of coverage of outpatient prescription drugs under such program; to the Committee on Finance.

By Mr. SARBANES (for himself, Mr. BAUCUS, Mr. BAYH, Mr . CLELAND, Mr. CORZINE, Mr. DODD, Mrs. FEINSTEIN, Mr. REID, Mr. SCHUMER, Ms. SNOWE, Ms. STABENOW, Mr. THOMPSON, and Mr. WYDEN):

S. 1136. A bill to provide for mass transportation in certain Federally owned or managed areas that are open to the general public; to the Committee on Energy and Natural Resources.

By Mr. HARKIN (for himself and Mr. GRASSLEY):

S. 1137. A bill to direct the Secretary of the Army to convey the remaining water supply storage allocation in Rathbun Lake, Iowa, to the Rathbun Regional Water Association; to the Committee on Environment and Public Works.

## ADDITIONAL COSPONSORS

S. 155

At the request of Mr. BINGAMAN, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of S. 155, a bill to amend title 5, United States Code, to eliminate an inequity in the applicability of early retirement eligibility requirements to military reserve technicians.

S. 212

At the request of Mr. CAMPBELL, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 212, a bill to amend the Indian Health Care Improvement Act to revise and extend such Act.

S. 280

At the request of Mr. JOHNSON, the name of the Senator from Michigan (Mr. LEVIN) was added as a cosponsor of S. 280, a bill to amend the Agriculture Marketing Act of 1946 to require retailers of beef, lamb, pork, and perishable agricultural commodities to inform consumers, at the final point of sale to consumers, of the country of origin of the commodities.

S. 592

At the request of Mr. SANTORUM, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 592, a bill to amend the Internal Revenue Code of 1986 to create Individual Development Accounts, and for other purposes.

S. 634

At the request of Ms. COLLINS, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of S. 634, a bill to amend section 2007 of the Social Security Act to provide grant funding for additional Enterprise Communities, and for other purposes.

S. 661

At the request of Mr. THOMPSON, the names of the Senator from Mississippi (Mr. COCHRAN) and the Senator from Nebraska (Mr. HAGEL) were added as cosponsors of S. 661, a bill to amend the Internal Revenue Code of 1986 to repeal the 4.3-cent motor fuel excise taxes on railroads and inland waterway transportation which remain in the general fund of the Treasury.

S. 677

At the request of Mr. HATCH, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of S. 677, a bill to amend the Internal Revenue Code of 1986 to repeal the required use of certain principal repayments on mortgage subsidy bond financing to redeem bonds, to modify the purchase price limitation under mortgage subsidy bond rules based on median family income, and for other purposes.

S. 775

At the request of Mrs. LINCOLN, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of S. 775, a bill to amend title XVIII of the Social Security Act to permit expansion of medical residency training programs in geriatric medicine and to provide for reimbursement of care coordination and assessment services provided under the medicare program.

S. 778

At the request of Mr. HAGEL, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 778, a bill to expand the class of beneficiaries who may apply for adjustment of status under section 245(i) of the Immigration and Nationality Act by extending the deadline for classification petition and labor certification filings.

S. 814

At the request of Mr. DODD, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of S. 814, a bill to establish the Child Care Provider Retention and Development Grant Program and the Child Care Provider Scholarship Program.

S. 818

At the request of Mr. HATCH, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 818, a bill to amend the Internal Revenue Code of 1986 to provide a long-term capital gains exclusion for individuals, and to reduce the holding period for long-term capital gain treatment to 6 months, and for other purposes.

S. 913

At the request of Ms. SNOWE, the names of the Senator from Delaware (Mr. CARPER), the Senator from Maryland (Mr. SARBANES), and the Senator from Maine (Ms. COLLINS) were added as cosponsors of S. 913, a bill to amend title XVIII of the Social Security Act to provide for coverage under the medicare program of all oral anticancer drugs.

S. 940

At the request of Mr. DODD, the name of the Senator from New York (Mrs. CLINTON) was added as a cosponsor of S. 940, a bill to leave no child behind.

S. 992

At the request of Mr. NICKLES, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 992, a bill to amend the Internal Revenue Code of 1986 to repeal the provision taxing policy holder dividends of mutual life insurance companies and to repeal the policyholders surplus account provisions.

S. 1032

At the request of Mr. FRIST, the names of the Senator from Utah (Mr. HATCH) and the Senator from Ohio (Mr. DEWINE) were added as cosponsors of S. 1032, a bill to expand assistance to countries seriously affected by HIV/AIDS, malaria, and tuberculosis.

S. 1037

At the request of Mrs. HUTCHISON, the names of the Senator from Alaska (Mr. MURKOWSKI) and the Senator from Connecticut (Mr. LIEBERMAN) were added as cosponsors of S. 1037, a bill to amend title 10, United States Code, to authorize disability retirement to be granted posthumously for members of the Armed Forces who die in the line of duty while on active duty, and for other purposes.

S. 1038

At the request of Mr. JEFFORDS, the names of the Senator from Idaho (Mr. CRAIG) and the Senator from Colorado (Mr. ALLARD) were added as cosponsors of S. 1038, a bill to amend the Internal Revenue Code of 1986 to improve access to tax-exempt debt for small nonprofit health care and educational institutions.

S. 1075

At the request of Mr. JOHNSON, his name was added as a cosponsor of S. 1075, a bill to extend and modify the Drug-Free Communities Support Program, to authorize a National Community Antidrug Coalition Institute, and for other purposes.

S. 1087

At the request of Mr. CONRAD, the names of the Senator from Texas (Mr. GRAMM) and the Senator from Georgia (Mr. MILLER) were added as cosponsors of S. 1087, a bill to amend the Internal Revenue Code of 1986 to provide a shorter recovery period of the depreciation of certain leasehold improvements.

S. RES. 71

At the request of Mr. HARKIN, the names of the Senator from Florida (Mr. GRAHAM), the Senator from Florida (Mr. NELSON), and the Senator from California (Mrs. BOXER) were added as cosponsors of S. Res. 71, a resolution expressing the sense of the Senate regarding the need to preserve six day mail delivery.

S. RES. 99

At the request of Mr. CAMPBELL, the names of the Senator from Mississippi

(Mr. COCHRAN), the Senator from New Jersey (Mr. CORZINE), the Senator from North Dakota (Mr. DORGAN), the Senator from Illinois (Mr. FITZGERALD), and the Senator from Wyoming (Mr. THOMAS) were added as cosponsors of S. Res. 99, a resolution supporting the goals and ideals of the Olympics.

S. CON. RES. 45

At the request of Mr. FITZGERALD, the name of the Senator from Georgia (Mr. CLELAND) was added as a cosponsor of S. Con. Res. 45, a concurrent resolution expressing the sense of Congress that the Humane Methods of Slaughter Act of 1958 should be fully enforced so as to prevent needless suffering of animals.

S. CON. RES. 52

At the request of Mr. CORZINE, the name of the Senator from Hawaii (Mr. AKAKA) was added as a cosponsor of S. Con. Res. 52, a concurrent resolution expressing the sense of Congress that reducing crime in public housing should be a priority, and that the successful Public Housing Drug Elimination Program should be fully funded.

AMENDMENT NO. 814

At the request of Mr. SANTORUM, the names of the Senator from New Hampshire (Mr. SMITH) and the Senator from Ohio (Mr. DEWINE) were added as cosponsors of amendment No. 814 proposed to S. 1052, a bill to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage.

AMENDMENT NO. 826

At the request of Ms. COLLINS, the name of the Senator from Virginia (Mr. ALLEN) was added as a cosponsor of amendment No. 826 proposed to S. 1052, a bill to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage.

AMENDMENT NO. 827

At the request of Mr. DOMENICI, the name of the Senator from Utah (Mr. HATCH) was added as a cosponsor of amendment No. 827 intended to be proposed to S. 1052, a bill to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage.

## STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. BINGAMAN (for himself, and Mr. DOMENICI):

S. 1118. A bill to amend the Intermodal Surface Transportation Efficiency Act of 1991 to identify certain routes in New Mexico as part of the Ports-to-Plains Corridor, a high priority corridor on the National Highway System; to the Committee on Commerce, Science, and Transportation.

Mr. BINGAMAN. Mr. President, I rise today to introduce legislation to promote the future economic vitality of the communities in Union and Colfax Counties, and throughout Northeast New Mexico. Our bill designates the route for New Mexico's section of the Ports-to-Plains High Priority Corridor, which runs 1000 miles from Laredo, Texas, to Denver, Colorado. I am pleased to have my colleague, Senator DOMENICI, as a cosponsor.

I am certain every senator recognizes the importance of basic transportation infrastructure to economic development in their State. Roads and airports link a region to the world economy.

In New Mexico, it is well known that regions with four-lane highways and economical commercial air service will most readily attract new jobs. I have long pressed at the Federal level to ensure our communities have the roads and airports they need for their long-term economic health. That is why this bill I am introducing today is so important. With the passage of NAFTA, the Ports-to-Plains corridor is centrally situated to serve international trade and promote economic development along its entire route.

In 1998 Congress identified the corridor from the border with Mexico to Denver, CO, as a High Priority Corridor on the National Highway System. Last year, a comprehensive study was undertaken to determine the feasibility of creating a continuous four-lane highway along the corridor. Alternative highway alignments for the trade corridor were also developed and evaluated. The study was conducted under the direction of a steering committee consisting of the State departments of transportation in Texas, New Mexico, Oklahoma, and Colorado.

It is important to note that public input was an important facet at every stage of the study. The steering committee sponsored public meetings in May of last year in Clayton, NM, and five other locations along the corridor. A final series of seven public meetings was held this year. I note that the level of public interest and participation was highest in New Mexico. Over 600 citizens attended the public meeting in Raton, NM, on March 6, 2001, while a total of only 700 people attended all six of the other public meetings in Texas, Oklahoma, and Colorado clearly demonstrating the importance of this trade corridor designation to Northeast New Mexico. A final report has just been prepared and a summary can be found on the web at www.wilbursmith.com/portstoplains.

The study evaluated two routes for the trade corridor between Amarillo, TX, and Denver, CO. One route ran along U.S. Highway 64/87 between Clayton and Raton, NM. The other followed U.S. Highway 287, bypassing New Mexico. The feasibility study found that either route between Amarillo and Denver would result in favorable conditions. However, the alignment through New Mexico, from Clayton to Raton, along U.S. Highway 64/87, was dramatically more favorable than the alternative in terms of travel efficiency, benefits and feasibility, including travel time savings and accident cost reduction. In particular:

The benefit-to-cost ratio of the New Mexico route was 75 percent better than for the route bypassing New Mexico.

The traffic volume in 2025 would be 150 percent higher on the New Mexico corridor than on the alternative, including 25 percent more trucks.

Two thirds of the New Mexico alignment is already four lanes wide or is soon slated to be widened to four lanes, compared to only one-third of the alternative alignment.

The alternative would require acquisition of more than twice the right-of-way and would displace nearly three times more residential and commercial facilities.

The New Mexico alignment would serve a population of nearly 2 million persons, compared to 1.5 million for the alternative.

Finally, the construction costs of the New Mexico alignment are $175 million less than the route bypassing New Mexico.

The alternative route had a very slight advantage over the New Mexico alignment only in economic development benefits.

With the feasibility study results now complete, The New Mexico Highway Commission last week voted unanimously to support the designation New Mexico's portion of the Ports-to-Plains Trade High Priority Corridor along U.S. Highway 64/87 between Clayton and Raton. The designated route connects into Texas along Highway 87 to Dumas, and to Denver along Interstate 25.

Very simply, this bill advances the same goal, to designate the route between Clayton and Raton in New Mexico as part of the Ports-to-Plains Corridor. As the huge turnout for the public meeting in Raton in March clearly demonstrates, there is overwhelming public support for this route throughout Union and Colfax Counties in New Mexico. There is also very strong support in neighboring Las Animas and Pueblo Counties in Colorado, including the cities of Trinidad and Pueblo.

In Texas, the state already plans to widen to four lanes its portion of the route between Dumas and the New Mexico state line. In New Mexico, the Citizens' Highway Assessment Task Force identified the route between Clayton and Raton as a priority to upgrade to four lanes. The initial needs and purposes study for the project is currently listed in New Mexico's five-year Statewide Transportation Improvement Study, STIP.

In addition to possible routes north of Amarillo, TX, I should also note that the feasibility study considered a variety of alternative routes south of Amarillo, on down to Laredo. However, Congress already indicated its preferred southern leg in the Omnibus Appropriations Act of 2001, though the

Congressional designation of the southern route was enacted long before we had the results of the feasibility study. The Texas Transportation Commission is voting today to confirm Congress' designation of the southern leg.

The studies have now been completed. The results are in. The route south of Amarillo has been set. Congress should now complete the designation of the final leg of the Ports-to-Plains Trade Corridor by passing our bill.

The time to act is now. Once the route is established the States can move forward with their regional and statewide transportation plans, environmental studies, design work, acquisition of rights of way, and initial construction of the most critical segments.

I thank Senator DOMENICI for cosponsoring the bill, and I hope all senators will join us in support of this important legislation.

I ask unanimous consent that a copy of the New Mexico State Highway Commission's resolution and the text of the bill be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 1118

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. IDENTIFICATION OF PORTS-TO-PLAINS HIGH PRIORITY CORRIDOR ROUTES IN NEW MEXICO AND COLORADO.**

Section 1105(c)(38) of the Intermodal Surface Transportation Efficiency Act of 1991 (105 Stat. 2032; 114 Stat. 2763A–201) is amended—

(1) in subparagraph (A), by redesignating clauses (i) through (viii) as subclauses (I) through (VIII), respectively;

(2) by redesignating subparagraph (A) as clause (i);

(3) by striking ''(38) The'' and inserting ''(38)(A) The'';

(4) in subparagraph (A) (as designated by paragraph (3))—

(A) in clause (i) (as redesignated by paragraph (2))—

(i) in subclause (VII) (as redesignated by paragraph (1)), by striking ''and'' at the end;

(ii) in subclause (VIII) (as redesignated by paragraph (1)), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following:

''(IX) United States Route 87 from Dumas to the border between the States of Texas and New Mexico.''; and

(B) by adding at the end the following:

''(ii) In the States of New Mexico and Colorado, the Ports-to-Plains Corridor shall generally follow—

''(I) United States Route 87 from the border between the States of Texas and New Mexico to Raton, New Mexico; and

''(II) Interstate Route 25 from Raton, New Mexico, to Denver, Colorado.''; and

(5) by striking ''(B) The corridor designation contained in paragraph (A)'' and inserting the following:

''(B) The corridor designation contained in subclauses (I) through (VIII) of subparagraph (A)(i)''.

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STATE OF NEW MEXICO, STATE HIGHWAY COMMISSION, RESOLUTION NO 2001–3 (JUN)

Whereas, in the Transportation Equity Act for the 21st Century (Public Law 105–178, Section 1211) Congress designated the Ports to Plains Corridor (Corridor), from the Mexican border via I–27 (in Texas) to Denver, Colorado, as one of 43 High Priority Corridors to integrate regions and to improve the efficiency and safety of commerce and travel and to promote economic development; and

Whereas, the Texas Department of Transportation has identified the highways in Texas that it will recommend to the Federal Highway Administration be part of the Corridor from Laredo to Dumas, but has deferred to the States of New Mexico, Oklahoma, and Colorado to reach a consensus on the recommendation of highways to complete the Corridor from Dumas to Denver; and

Whereas, a feasibility study (Study) under the direction of a steering committee made up of representatives of the affected states, has identified two alternatives to complete the Corridor from Amarillo to Denver. The first alternative designated N1, goes from Amarillo (following U.S. 287) to Dumas, Texas, then follows U.S. 87 and U.S. 64/87 from Dumas, through Clayton, New Mexico, to Raton, New Mexico, and then continues to Denver following I–25 through Trinidad, Pueblo, and Colorado Springs, Colorado. The second alternative, designated N4, bypasses New Mexico by following U.S. 287 through Boise City, Oklahoma to Lamar and Limon, Colorado and then follows I–70 to Denver; and

Whereas, the public participation process of the Study reflects overwhelming support in the communities and related areas of Clayton, Raton, Trinidad, and Pueblo for the N1 alternative; and

Whereas, the N1 alternative will better serve the intent of Congress in creating the High Priority Corridor program because it will integrate more regional population centers and provide greater opportunities for economic development than the N4 alternative, which bypasses these population centers and thus limits the potential for economic development; and

Whereas, the N4 alternative will cost more to construct than the N1 alternative because the N4 alternative will require the construction of more new four land highway, including the cost of right of way acquisition; and

Whereas, portions of I–25 in alternative N1 from Denver to Colorado Springs are being improved and need additional improvements to better serve current needs and this Commission understands that a bypass on the Interstate Highway System for Colorado Springs is in conceptual plans of the Colorado Department of Transportation: Now, therefore it is

*Resolved by the State Highway Commission,* That it supports the N1 alternative to bring the Ports to Plains Corridor through New Mexico on U.S. 64/87, including upgrading U.S. 64/87 in New Mexico to a four-lane highway, in order to achieve the intent of Congress in the High Priority Corridor program to integrate regional population centers and provide opportunities for economic development; and it is further

*Resolved,* That the State Highway Commission supports additional federal funding for improvements to I–25 in Colorado and a bypass of Colorado Springs if that plan is adopted by the Colorado Department of Transportation; and it is further

*Resolved,* That a copy of this Resolution be provided to the Ports to Plains Project Steering Committee and feasibility study consultant, the Texas, Oklahoma, and Colorado Departments of Transportation, the Federal Highway Administration, New Mexico, Division, the governing bodies of the municipalities of Trinidad, Pueblo, and Colorado Springs, Colorado, Clayton, Des Moines, Raton, Springer, Cimarron, Eagle Nest, Angel Fire, Taos, Questa, and Red River, New Mexico and Union, Colfax, and Taos Counties, New Mexico, the New Mexico Municipal League, the New Mexico Association of Counties, all members of the New Mexico Congressional delegation, and all members of the New Mexico Legislative leadership.

Adopted in open meeting by the State Highway Commission on June 21, 2001.

Mr. DOMENICI. Mr. President, I rise today to support the Ports-to-Plains NAFTA corridor designation through New Mexico, along U.S. Highway 64/87 from Clayton to Raton.

From the beginning, I have vigorously supported the proposed route through New Mexico. In fact, while a member of the Senate Appropriations Subcommittee on Transportation, I worked to make the proposed route through New Mexico a possibility.

Further, representatives from my office attended a public comment meeting on the route in Raton, New Mexico in March 2001. I thought it important that the more than three hundred New Mexicans in attendance know that I was behind them.

I have supported the route from the beginning because I knew that it would be good for the people of my state and good for the country.

The conclusions of the feasibility study give clear and convincing evidence supporting what I had suspected all along. The route through New Mexico, known as the N–1 route, is the best choice.

In order to demonstrate that a particular infrastructure best meets the public interest over another, one must consider a host of factors.

Those factors include considering the public's preferences, the cost of the competing projects, and the relative efficiency of implementing each project.

The feasibility study concluded that the Ports-to-Plain route best meets this criteria.

The traveling public overwhelmingly prefers the route through New Mexico, which carries 28,000 vehicles per day. The competing proposal only has traffic flows of 11,000 vehicles each day.

The N–1 route through New Mexico represents the best deal for the taxpayer since it costs $175 million less than the competing route.

Last, the route through New Mexico would be the most efficient to implement since sixty-seven percent of the highway has already been programmed for four-lane expansion. The competing route has only programmed thirty-seven percent of the road for crucial four-lane improvements.

Furthermore, the State of New Mexico is committed to securing the Ports-to-Plains designation. Evidencing that commitment, the State's Highway Commission recently passed a resolution supporting the Ports-to Plains designation from Dumas, Texas to Raton, New Mexico.

I pledge to continue working to ensure that the Ports-to-Plains corridor is designated through New Mexico. The route through Raton, New Mexico is the most efficient and cost effective

option for the U.S. taxpayer, furthers the interest of the people of my State, and is supported by the State government.

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By Mr. LEAHY (for himself, Mr. DEWINE, Mr. DASCHLE, Mr. COCHRAN, Mrs. CARNAHAN, Ms. SNOWE, and Mr. JOHNSON):

S. 1119. A bill to require the Secretary of Defense to carry out a study of the extent to the coverage of members of the Selected Reserve of the Ready Reserve of the Armed Forces under health benefits plans and to submit a report on the study of Congress, and for other purposes; to the Committee on Armed Services.

Mr. LEAHY. Mr. President, I rise today to introduce important legislation that will impact the health and readiness of the Selected Reserve. The Selected Reserves includes over 900,000 dedicated men and women divided between the National Guard and the Reserves. Over the past ten years, this force has become increasingly critical to carrying out our Nation's defense, whether deploying to far-flung regions of the globe or backfilling for other units making those deployments.

The country simply cannot meet its commitments without these proud citizen-soldiers. It follows, then, that steps to increase the readiness of the Selected Reserves will have a positive effect on the readiness of the entire force. It was this goal in mind that I introduce the Health Care for Selected Reserve Act.

This legislation will ensure that all members of the drilling reserves have adequate health insurance. The legislation acknowledges our reserves' continuing contributions to the defense of the Nation and expresses the need for full medical coverage. The legislation will commission an independent study on the extent of insurance shortfalls and examine the feasibility of extending the TRICARE or FEHBP program to the reserves.

Currently, when a member of the Selected Reserve goes on active duty over 60 days, they are provided full coverage under the TRICARE Prime program conducted through the active military's medical treatment facilities. But when reservists are not on active duty, they are left to gain insurance through their civilian employers. Like the rest of society, most gain adequate coverage through their employers like the rest of society, but, mirroring broader shortfalls in the wider population, many go without any health coverage at all. This shortfall has an even more noticeable affect on the country because it affects military readiness.

There is also an underlying issue of fairness here. It seems wrong to me that one week someone can be patrolling the skies over Iraq with full coverage and the next week they can have no health coverage at all. That situation gives the impression that the National Guard and the Reserves are the poorly-paid subcontractor to the active duty force. If we really believe in the idea of the Total Force, we cannot let these health coverage shortfalls exist.

I want to thank the other sponsors of this bill for helping me craft this bill. Senators DEWINE, DASCHLE, COCHRAN, CARNAHAN, SNOWE, and JOHNSON are deeply interested in this issue, and I look forward to working with them to develop a set of concrete steps to meet this problem. I urge the legislation's adoption.

Mr. President, I ask unanimous consent that the full text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1119

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. FINDINGS.**

Congress makes the following findings:

(1) The Selected Reserve of the Ready Reserve of the Armed Forces is the element of the Armed Forces of the United States that has the capability quickly to augment the active duty forces of the Armed Forces successfully in times of crisis.

(2) The Selected Reserve has been assigned increasingly critical levels of responsibility for carrying out the worldwide military missions of the Armed Forces since the end of the Cold War.

(3) Members of the Selected Reserve have served proudly as mobilized forces in numerous theaters from Europe to the Pacific and South America, indeed, around the world.

(4) The active duty forces of the Armed Forces cannot successfully perform all of the national security missions of the Armed Forces without augmentation by the Selected Reserve.

(5) The high and increasing tempo of activity of the Selected Reserve causes turbulence in the relationships of members of the Selected Reserve with their families, employers, and reserve units.

(6) The turbulence often results from lengthy, sometimes year-long, absences of the members of the Selected Reserve from their families and their civilian jobs in the performance of military duties necessary for the execution of essential missions.

(7) Family turbulence includes the difficulties associated with vacillation between coverage of members' families for health care under civilian health benefits plans and coverage under the military health benefits options.

(8) Up to 200,000 members of the Selected Reserve, including, in particular, self-employed members, do not have adequate health benefits.

**SEC. 2. SENSE OF CONGRESS.**

It is the sense of Congress that steps should be taken to ensure that every member of the Selected Reserve of the Ready Reserve of the Armed Forces and the member's family have health care benefits that are adequate—

(1) to ease the transition of the member from civilian life to full-time military life during a mobilization of reserve forces;

(2) to minimize the adverse effects of a mobilization on the member's ability to provide for the member's family to have ready access to adequate health care; and

(3) to improve readiness and retention in the Selected Reserve.

**SEC. 3. STUDY OF HEALTH CARE BENEFITS COVERAGE FOR MEMBERS OF THE SELECTED RESERVE.**

(a) REQUIREMENT FOR STUDY.—The Secretary of Defense shall enter into a contract with a federally funded research and development center to carry out a study of the needs of members of the Selected Reserve of the Ready Reserve of the Armed Forces and their families for health care benefits.

(b) REPORT.—(1) Not later than March 1, 2002, the Secretary shall submit a report on the results of the study to Congress.

(2) The report shall include the following matters:

(A) Descriptions, and an analysis, of how members of the Selected Reserve and their dependents currently obtain coverage for health care benefits, together with statistics on enrollments in health care benefits plans.

(B) The percentage of members of the Selected Reserve, and dependents of such members, who are not covered by any health insurance or other health benefits plan, together with the reasons for the lack of coverage.

(C) Descriptions of the disruptions in health benefits coverage that a mobilization of members of the Selected Reserve causes for the members and their families.

(D) At least three recommended options for cost-effectively preventing or reducing the disruptions by means of extending health care benefits under the Defense Health Program or the Federal Employees Health Benefits program to all members of the Selected Reserve and their families, together with an estimate of the costs of individual coverage and family coverage under each option.

(E) A profile of the health status of members of the Selected Reserve and their dependents, together with a discussion of how that profile would affect the cost of providing adequate health benefits coverage for that population of beneficiaries.

(F) An analysis of the likely effects that providing enhanced health benefits coverage to members of the Selected Reserve and their families would have on recruitment and retention for, and the readiness of, the Selected Reserve.

(3) In formulating the options to recommend under paragraph (2)(D), the Secretary shall consider an expansion of the TRICARE program or the Federal Employees Health Benefits program to cover the members of the Selected Reserve and their families.

Mr. DASCHLE. Mr. President, today I join with several important leaders of the Senate's National Guard Caucus to introduce S. 1119, which we believe will one day result in improved health care for Guard and Reserve members and their families.

It is appropriate that we introduce this now, during a week in which Senate floor debate has focused almost exclusively on health care, with several lively discussions about the importance of expanding health coverage to the uninsured.

Unfortunately, Guard members and leaders in South Dakota tell me that many of the uninsured serve in the National Guard. Many of them work for small businesses that cannot afford to offer health insurance to their employees. Some of them have insurance for themselves, but cannot afford to insure their dependents.

Meanwhile, this Nation is utilizing the Guard more heavily than at any other time in our Nation's history. During the Cold War, a Guard member

might serve and retire without ever being called to active duty. Staring with the Persian Gulf War and continuing to this day in Bosnia, Kosovo and Iraq, reservists are serving alongside the active duty military during deployments that can last 6 months or more.

Each of these deployments strains the Guard member's employer, who temporarily gives up a valued employee. And it strains individual soldiers and their families, even if they have health insurance, because employer-provided coverage often lapses during periods of active duty.

The premise of our bill is that health coverage can help the Guard attract and retain top-flight personnel and also improve readiness; that it can help service members and their families, especially in coping with mobilization; and that it can relieve some of the burdens faced today by National Guard employers, particularly small businesses.

This bill lays the groundwork for a solution. S. 1119 would authorize a study by a non-government research center to explore the extent of the problem and recommend at least three cost-effective solutions, including the possibility of opening the TRICARE program or the Federal Employees Health Benefits Program to reservists and their families. The study would look at disruptions to health coverage caused by mobilizations and analyze the likely impact of enhanced health care on recruitment and retention.

We have developed this bill in consultation with the Military Coalition and several of its members. I appreciate their concern for this problem and their work to help develop a solution. In this regard, I would particularly like to acknowledge the role of the Enlisted Association of the National Guard of the United States, the Reserve Officers Association, the National Guard Association of the United States, and the Retired Officers Association.

I hope and believe that today's bill introduction can be an important step toward providing adequate health care for members of the South Dakota National Guard and other reservists around the Nation, who do so much on behalf of their communities, their States, and this Nation.

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By Mrs. BOXER (for herself and Mr. SMITH of Oregon):

S. 1120. A bill to amend the Foreign Assistance Act of 1961 to increase the authorization of appropriations for fiscal year 2002, and to authorize appropriations for fiscal year 2003, to combat HIV and AIDS, and for other purposes; to the Committee on Foreign Relations.

Mrs. BOXER. Mr. President, this week, as the United Nations meets to prepare a global strategy to combat the growing worldwide HIV–AIDS crisis, I am proud to introduce legislation aimed at ensuring that the United States continues to be a leader in the fight against this deadly disease.

I am pleased to once again join my good friend and colleague from Oregon, Senator SMITH, in introducing this bill. Last year, we teamed up to offer the Global AIDS Prevention Act that doubled funding for the United States Agency for International Development's HIV–AIDS programs. Not only was this legislation included in broader international health legislation which became law, it was also fully funded for the current fiscal year. This year, we are looking to build upon last year's success by again doubling the amount USAID spends on fighting the global HIV–AIDS epidemic.

The Global AIDS Research and Relief Act would authorize $600 million in each of the next two fiscal years. It is designed to complement international HIV–AIDS relief efforts so that a truly global response can be implemented in sub-Saharan Africa, Latin America, Southeast Asia, Russia, and all places where people are suffering from this epidemic.

In the 20 years since AIDS was first recognized, 22 million people worldwide have died from the disease, and 36 million more are living with HIV or AIDS today. Of those living with the disease, 95 percent live in the developing world where advanced technology to combat AIDS is not readily available. It is predicted that AIDS will soon become the deadliest infectious epidemic in world history, surpassing the Plague, which killed an estimated 25 million people.

This new chapter in the AIDS epidemic is especially tragic because its growth is preventable. While there is no cure for this horrible disease, progress is being made. New medical breakthroughs afford HIV-positive people a much greater life expectancy than they would have had ten years ago. Unfortunately, these efforts are not reaching the Nations whose people need help the most. By increasing authorization for USAID to establish and expand these valuable initiatives in developing countries, our bill helps to remedy this disparity in the quality of care.

Specifically, the bill addresses the need for increased voluntary testing and counseling, so that we can educate people and keep its spread in check. With this funding authorization, the USAID will be able to provide more for the most vulnerable constituencies, children and young adults. The money will be used for drugs like neviropine, which is given to expectant HIV-positive mothers to prevent the spread of the infection to their unborn children.

The United States is a trendsetter in efforts to address the pandemic of HIV–AIDS. Through the work of USAID, we have instituted prevention, care, and treatment programs in some of the hardest-hit countries in sub-Saharan Africa. The Centers for Disease Control and Prevention has worked with partners in other countries to expand treatment programs. Other agencies such as the Department of Labor, the Department of Agriculture and the Department of Defense are contributing to the effort to end the spread of AIDS. But far more remains to be done.

I urge my colleagues to support this measure and ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1120

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Global AIDS Research and Relief Act of 2001''.

**SEC. 2. DEFINITIONS.**

In this Act:

(1) AIDS.—The term ''AIDS'' means the acquired immune deficiency syndrome.

(2) ASSOCIATION.—The term ''Association'' means the International Development Association.

(3) BANK.—The term ''Bank'' or ''World Bank'' means the International Bank for Reconstruction and Development.

(4) HIV.—The term ''HIV'' means the human immunodeficiency virus, the pathogen, which causes AIDS.

(5) HIV/AIDS.—The term ''HIV/AIDS'' means, with respect to an individual, an individual who is infected with HIV or living with AIDS.

**SEC. 3. FINDINGS AND PURPOSES.**

(a) FINDINGS.—Congress makes the following findings:

(1) According to the Surgeon General of the United States, the epidemic of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) will soon become the worst epidemic of infectious disease in recorded history, eclipsing both the bubonic plague of the 1300s and the influenza epidemic of 1918–1919 which killed more than 20,000,000 people worldwide.

(2) According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), more than 36,100,000 people in the world today are living with HIV/AIDS, of which approximately 95 percent live in the developing world.

(3) UNAIDS data shows that among children age 15 and under worldwide, more than 4,300,000 have died from AIDS, more than 1,400,000 are living with the disease; and in 1 year alone—2000—an estimated 600,000 became infected, of which over 90 percent were babies born to HIV-positive women.

(4) Although sub-Saharan Africa has only 10 percent of the world's population, it is home to more than 25,300,000—roughly 70 percent—of the world's HIV/AIDS cases.

(5) Worldwide, there have already been an estimated 21,800,000 deaths because of HIV/AIDS, of which more than 80 percent occurred in sub-Saharan Africa.

(6) According to UNAIDS, by the end of 1999, 13,200,000 children have lost at least one parent to AIDS, including 12,100,000 children in sub-Saharan Africa, and are thus considered AIDS orphans.

(7) At current infection and growth rates for HIV/AIDS, the National Intelligence Council estimates that the number of AIDS orphans worldwide will increase dramatically, potentially increasing threefold or more in the next 10 years, contributing to economic decay, social fragmentation, and political destabilization in already volatile and strained societies. Children without care or hope are often drawn into prostitution, crime, substance abuse, or child soldiery.

(8) The discovery of a relatively simple and inexpensive means of interrupting the transmission of HIV from an infected mother to the unborn child—namely with nevirapine (NVP), which costs $4 a tablet—has created a great opportunity for an unprecedented partnership between the United States Government and the governments of Asian, African, and Latin American countries to reduce mother-to-child transmission (also known as ''vertical transmission'') of HIV.

(9) According to UNAIDS, if implemented this strategy will decrease the proportion of orphans that are HIV-infected and decrease infant and child mortality rates in these developing regions.

(10) A mother-to-child antiretroviral drug strategy can be a force for social change, providing the opportunity and impetus needed to address often longstanding problems of inadequate services and the profound stigma associated with HIV-infection and the AIDS disease. Strengthening the health infrastructure to improve mother-and-child health, antenatal, delivery, and postnatal services, and couples counseling generates enormous spillover effects toward combating the AIDS epidemic in developing regions.

(11) A January 2000 United States National Intelligence Estimate (NIE) report on the global infectious disease threat concluded that the economic costs of infectious diseases—especially HIV/AIDS—are already significant and could reduce GDP by as much as 20 percent or more by 2010 in some sub-Saharan African nations.

(12) The HIV/AIDS epidemic is of increasing concern in other regions of the world, with UNAIDS estimating that there are more than 5,800,000 cases in South and Southeast Asia, that the rate of HIV infection in the Caribbean is second only to sub-Saharan Africa, and that HIV infections have doubled in just 2 years in the former Soviet Union.

(13) Russia is the new ''hot spot'' for the pandemic and more Russians are expected to be diagnosed with HIV/AIDS by the end of 2001 than all cases from previous years combined.

(14) Despite the discouraging statistics on the spread of HIV/AIDS, some developing nations—such as Uganda, Senegal, and Thailand—have implemented prevention programs that have substantially curbed the rate of HIV infection.

(15) Accordingly, United States financial support for medical research, education, and disease containment as a global strategy has beneficial ramifications for millions of Americans and their families who are affected by this disease, and the entire population, which is potentially susceptible.

(b) PURPOSES.—The purposes of this Act are to—

(1) help prevent human suffering through the prevention, diagnosis, and treatment of HIV/AIDS; and

(2) help ensure the viability of economic development, stability, and national security in the developing world by advancing research to—

(A) understand the causes associated with HIV/AIDS in developing countries; and

(B) assist in the development of an AIDS vaccine.

**SEC. 3. ADDITIONAL ASSISTANCE AUTHORITIES TO COMBAT HIV AND AIDS.**

Paragraphs (4) through (6) of section 104(c) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c)) are amended to read as follows:

''(4)(A) Congress recognizes the growing international dilemma of children with the human immunodeficiency virus (HIV) and the merits of intervention programs aimed at this problem. Congress further recognizes that mother-to-child transmission prevention strategies can serve as a major force for change in developing regions, and it is, therefore, a major objective of the foreign assistance program to control the acquired immune deficiency syndrome (AIDS) epidemic.

''(B) The agency primarily responsible for administering this part shall—

''(i) coordinate with UNAIDS, UNICEF, WHO, national and local governments, other organizations, and other Federal agencies to develop and implement effective strategies to prevent vertical transmission of HIV; and

''(ii) coordinate with those organizations to increase intervention programs and introduce voluntary counseling and testing, antiretroviral drugs, replacement feeding, and other strategies.

''(5)(A) Congress expects the agency primarily responsible for administering this part to make the human immunodeficiency virus (HIV) and the acquired immune deficiency syndrome (AIDS) a priority in the foreign assistance program and to undertake a comprehensive, coordinated effort to combat HIV and AIDS.

''(B) Assistance described in subparagraph (A) shall include help providing—

''(i) primary prevention and education;

''(ii) voluntary testing and counseling;

''(iii) medications to prevent the transmission of HIV from mother to child;

''(iv) programs to strengthen and broaden health care systems infrastructure and the capacity of health care systems in developing countries to deliver HIV/AIDS pharmaceuticals, prevention, and treatment to those afflicted with HIV/AIDS; and

''(v) care for those living with HIV or AIDS.

''(6)(A) In addition to amounts otherwise available for such purpose, there is authorized to be appropriated to the President $600,000,000 for each of the fiscal years 2002 and 2003 to carry out paragraphs (4) and (5).

''(B) Of the funds authorized to be appropriated under subparagraph (A), not less than 65 percent is authorized to be available through United States and foreign nongovernmental organizations, including private and voluntary organizations, for-profit organizations, religious affiliated organizations, educational institutions, and research facilities.

''(C)(i) Of the funds authorized to be appropriated by subparagraph (A), priority should be given to programs that address the support and education of orphans in sub-Saharan Africa, including AIDS orphans and prevention strategies for vertical transmission referred to in paragraph (4)(A).

''(ii) Assistance made available under this subsection, and assistance made available under chapter 4 of part II to carry out the purposes of this subsection, may be made available notwithstanding any other provision of law that restricts assistance to foreign countries.

''(D) Of the funds authorized to be appropriated by subparagraph (A), not more than 7 percent may be used for the administrative expenses of the agency primarily responsible for carrying out this part of this Act in support of activities described in paragraphs (4) and (5).

''(E) Funds appropriated under this paragraph are authorized to remain available until expended.''.

Mr. SMITH of Oregon. Mr. President, I rise today to join my colleague Senator BOXER to introduce the ''Global AIDS Research and Relief Act of 2001.'' This important legislation increases the authorization for USAID to carry out its prevention, treatment and care programs to $600 million for fiscal years 2002 and 2003. These additional resources will help prevent human suffering through the prevention, diagnosis and treatment of HIV/AIDS.

The world is facing a global health problem of disastrous proportions in the global HIV/AIDS pandemic. In the past year, this issue has received much needed attention from the international community and the U.S. Government. But, unfortunately, our efforts and the efforts of other governments, the private sector, and foundations have not been enough and the pandemic continues to wreak havoc on the lives of millions of people around the world. The United States plays a key role in the global effort and our bill seeks to strengthen those efforts.

Over 58 million people have already been infected with HIV/AIDS and 36 million people are living today with HIV/AIDS. Of those living with the disease, over 95 percent live in the developing world where the economic and social structures in those countries are being destroyed. Sub-Saharan Africa is truly an epicenter for this disease, but increasingly, people are becoming infected in Asia, the Caribbean, and Eastern Europe. Soon, HIV/AIDS will become the worst infectious disease epidemic in recorded history, causing more deaths than both the bubonic plague of the 1930s and the influenza epidemic of 1918–1919.

Young adults and children have been particularly hard hit by the pandemic. Among children under the age of 15, more than 4.3 million have died of AIDS and more than 1.4 million are living with AIDS. Just last year, 600,000 young people became infected and over 90 percent were babies born to HIV-positive mothers.

HIV/AIDS is also hitting those between the ages of 15—24. In some sub-Saharan African countries, the infection rates are more than 40 percent in this population. These high infection rates will have a significant impact on the social and economic health of developing nations. The United States Census Bureau has found the life expectancy in sub-Saharan Africa has fallen almost 30 years within a decade. By 2010, it is estimated that the average life expectancy in Botswana will be 29 years of age, 30 years in Swaziland, 33 years in Namibia, and 36 years in South Africa. Millions of young adults are losing their lives and this will significantly impact the economic and political viability of these Nations. Some Nations are estimated to have a reduced GDP of at least 20 percent or more by 2010 due to decreased productivity of its workers. Over the past thirty years, the United States has invested millions of dollars in democracy building programs and economic stabilization programs. HIV/AIDS has quickly erased much of this progress.

As we look to the future of the world, we are also confronted by the problem of AIDS orphans. USAID estimates that there will be 44 million orphans by 2010. Without a parent or family to

care for them, many will be drawn into prostitution, crime, substance abuse or child soldiery. Furthermore, without stability many of these children will not seek help when they are sick. AIDS threatens to reverse years of steady progress of child survival in developing countries.

The prevalence of HIV/AIDS in the young will have a significant impact on the economic future of the world. The pandemic is contributing to economic decay, social fragmentation, and political destabilization in already strained and volatile societies. These factors are of particular concern in South and Southeast Asia, the Caribbean, Eastern Europe, and the former Soviet Union where the pandemic is just beginning to become a problem. It is estimated that there are more than 5.8 million cases in South and Southeast Asia and the rate of HIV infection in the Caribbean is second only to sub-Saharan Africa. Russia is the new ''hot spot'' for HIV/AIDS. More Russians are expected to be diagnosed with HIV/AIDS by the end of 2001 than all cases from previous years combined. Many of these countries do not yet have prevention, treatment and care programs in place and we must equip our federal agencies with the resources and flexibility needed to address the pandemic in all of these areas.

The United States is seen as a leader in efforts to address the epidemic. We contributed almost $500 million to fight HIV/AIDS in fiscal year 2001. Through programs at the U.S. Agency for International Development, we have instituted prevention, care and treatment programs in some of the worst hit countries in sub-Saharan Africa. At the Centers for Disease Control and Prevention, we have worked with partners in other countries to expand treatment and home-based care programs. Other agencies, including the Department of Labor, the Department of Defense, and the Department of Agriculture have contributed in their areas of expertise.

This legislation recognizes the growing problems encountered by children around the world and instructs USAID to make efforts to prevent mother-to-child transmission and orphan programs a major objective of their program. Through coordination with UN agencies, national and local governments, non-governmental organizations and foundations, the U.S. government shall implement effective strategies to prevent vertical transmission of HIV. Further, the bill states that the agency must strengthen and expand all of its primary prevention and education programs.

This bill also calls on USAID to continue to provide support to research that will help the world to understand the causes associated with HIV/AIDS in developing countries and assist in the development of an effective AIDS vaccine.

I believe the ''Global AIDS Research and Relief Act of 2001'' can make a profound difference in the lives of millions of people facing the HIV/AIDS epidemic. I ask all my colleagues to join us and support this legislation at this critical moment in the spread of the disease.

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By Mr. FEINGOLD (for himself, Mr. CRAIG, and Mr. KOHL):

S. 1123. A bill to amend the Dairy Production Stabilization Act of 1983 to ensure that all persons who benefit from the dairy promotion and research program contribute to the cost of the program, and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

Mr. FEINGOLD. Mr. President, I rise today with my colleagues Senator CRAIG and Senator KOHL to introduce a modified version of the ''Dairy Promotion Fairness Act,'' which I introduced earlier this year. This legislation provides equity to domestic producers who have been paying into the Promotion Program while importers have gotten a free ride.

I introduce a revised version of this legislation, after I received suggestions on how to improve this legislation from America's dairy farmers. Their input is vital to enacting effective dairy legislation, and I thank all the dairy producers of my State not only for their views, but also their work to strengthen Wisconsin's rural economy.

Since the National Dairy Promotion and Research Board conducts only generic promotion and general product research, domestic farmers and importers alike benefit from these actions. The Dairy Promotion Fairness Act requires that all dairy product importers contribute to the program.

Unlike other agricultural commodity checkoff promotion programs, such as beef, cotton and eggs, the dairy checkoff program collects funds solely from domestic producers. Importers of dairy products do not have to pay into the program, yet they reap the benefits of dairy promotion.

I would also like to make sure my colleagues are aware that June is Dairy Month. This tradition of honoring our hard working dairy farmers, began as ''National Milk Month'' first held in the summer of 1937. Wisconsin celebrates this proud heritage every June by honoring our past accomplishments of Wisconsin as America's Dairy State.

Wisconsin became a leader in the dairy industry after the first dairy cow came to Wisconsin in the 1800's and by 1930 it earned the nickname, America's Dairyland. Dairy history and the State's history have been intertwined from the beginning. The people of Wisconsin are defined by the image of dairy farmers: hardworking, honest and the heirs of a great tradition.

I would like to share with you some of the accomplishments of Wisconsin's Dairy Farmers. Wisconsin is the No. 1 cheese-producing State in the country, with 28 percent of the total annual U.S. cheese production. Wisconsin's 130 cheese plants produce more than 350 varieties, types and styles of Wisconsin cheese.

We produce more than 2 billion pounds of cheese annually. We have more licensed cheese makers than any other state with some of the most stringent state standards for cheesemaking and overall dairy product quality. We lead the nation in the production of specialty cheeses, such as Gorgonzola, Gruyere (gru-yure), Asiago, Provolone, Aged Cheddar, Gouda, Blue, Feta and many others. In fact, we are the only producer of Limburger cheese in the country.

Colby, Wisconsin is the home Colby cheese. And Brick cheese was invented in Wisconsin, Brick is named for its shape, and because cheese makers originally used bricks to press moisture from the cheese.

Wisconsinites have recognized this proud tradition by holding over 100 dairy celebrations across our State, including dairy breakfasts, ice cream socials, cooking demonstrations, festivals and other events. These events are all designed to make the public aware of the quality, variety and great taste of Wisconsin dairy products and to honor the producers who make it all possible.

We must follow the lead of Wisconsin, and honor our dairy farmers by passing this legislation and halting the free ride dairy importers currently receive.

The Dairy Promotion Fairness Act supports the dairy marketing board's efforts to educate consumers on the nutritional value of dairy products. It also treats our farmers fairly by asking them not to bear the entire financial burden for a promotional program that benefits importers and domestic producers alike.

We have put our own producers at a competitive disadvantage for far too long. It's high time importers paid for their fair share of the program.

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By Mr. MCCONNELL (for himself, Mr. AKAKA, Mr. ALLARD, Mr. BAYH, Mr. BINGAMAN, Mr. CLELAND, Mr. COCHRAN, Mr. EDWARDS, Mr. FITZGERALD, Mr. FRIST, Mr. GRAHAM, Mr. HELMS, Mr. INHOFE, Mr. JEFFORDS, Mr. KENNEDY, Mr. KERRY, Mr. KOHL, Mr. KYL, Mr. LEAHY, Mr. LEVIN, Mr. REED, Mr. SMITH of Oregon, Mr. SMITH of New Hampshire, Mr. SPECTER, Mr. TORRICELLI, and Mr. WYDEN):

S. 1125. A bill to conserve global bear populations by prohibiting the importation, exportation, and interstate trade of bear viscera and items, products, or substances containing, or labeled or advertised as containing, bear viscera, and for other purposes; to the Committee on Environment and Public Works.

Mr. MCCONNELL. Mr. President, incredibly, there is a good chance that today someone will put on a facial cream, apply a medicine, or even eat a

soup that contains bear parts. Bear bile, gallbladders, paws and claws are found in culinary delicacies, cosmetics and traditional ethnic medicines in Asia, and these parts often fetch thousands of dollars. A cup of bear paw soup has sold for up to $1,500 in Taiwan, and wildlife experts say that a gallbladder can command tens of thousands of dollars on the Asian market. Not surprisingly, the lure of astronomical profits overseas has spawned rampant poaching of American bears. The United States Fish and Wildlife Service continues to find bear carcasses rotting with their gallbladders ripped out and their paws sliced off. Just today, creator Jack Elrod chronicled this heinous act in his wildlife preservation comic strip, ''Mark Trail.''

The slaughter of American black bears and the sale of their parts is a deliberate and dastardly plot hatched by a black market of poachers, traders, and smugglers who have been known to transport bear parts in cans of chocolate syrup or bottles of scotch. Because certain Asian bear populations are being poached to near extinction, poachers and smugglers often target American black bears to meet the demand for bear parts in Asia and even within certain communities here at home. In Oregon alone, one poaching-for-profit ring reportedly killed between 50–100 black bears a year for 5 to 10 years simply to harvest their gallbladders. While the bear population in North America presently is stable, the growth of illegal and inhumane poaching, coupled with the difficulty of anti-poaching enforcement efforts, could pose a real threat to our resident bear population. We should not stand by and allow American bears to be decimated by poachers.

The depleted bear populations in Asia suffer a different, but equally cruel, fate as they are ''protected'' to meet the demand for their bile. National Geographic, U.S News and World Report and The Los Angeles Times each have reported that Asiatic bears in China have been trapped in bear ''farms'' and milked for their bile through catheters inserted into their gallbladders. Bears in other countries often fare no better. In South Korea, for example, bears have been bludgeoned to death or boiled alive in front of patrons to prove they are purchasing authentic Asian bear parts.

Some States in America prohibit trading in bear parts. But others do not. And to make matters more complicated, some States prohibit such trading only if the bear was killed within that State. It hardly takes a lawyer to quickly find the loophole in such a law, poachers and black market profiteers can simply kill a bear in another State and take it back across State lines to sell the parts. And because it is almost impossible to tell where a bear was killed just by looking at its parts, traders and smugglers can always claim that the bear was killed out of State. So, as you can see, our conflicting web of State laws does little to deter poachers from their prey. In fact, the confusing labyrinth of laws may make it easier for poachers to slaughter still more bear.

To help bring the complex, sometimes criminal, and inhumane trade in bear parts to an end, I am once again introducing the Bear Protection Act. This legislation always has enjoyed broad, bipartisan support since I first introduced the bill in the 103rd Congress. Last year the bill passed this chamber by unanimous consent, only to be returned by the House under the blue-slip rule. I am proud to be joined by 25 original cosponsors of the bill today, including 14 Democrats, 10 Republicans and an Independent, and I hope that others soon will join me to help shepherd this important legislation to passage.

My legislation is straightforward. It prohibits the import, export, or sale of bear viscera, or any products containing bear viscera, and it imposes criminal and civil penalties for violators. Enacting a uniform Federal prohibition on the trade in bear parts is necessary to close the loopholes left open by the patchwork of State laws that have facilitated the illegal trade of bear parts in the United States and overseas.

This legislation will in no way affect the rights of sportsmen to hunt bears legally in any State. Illegal bear poaching and legal recreational hunting are separate and distinct acts. Indeed, we should remember that every bear poached for illegal profiteering of bear parts is a bear taken away from sportsmen. A former chief enforcement officer for the United States Fish and Wildlife Service has estimated that approximately 40,000 bears are hunted legally each year, but an almost equal number are poached illegally. Many States understand this problem, as over two-thirds of the States that allow bear hunting also ban the trade of bear parts.

This bill is another example of what I like to call consensus conservation. The legislation does not pit hunters against environmentalists. Nor does it pit States against the heavy hand of the Federal Government on wildlife management or sporting laws. Indeed, I am happy to report that there are no political fireworks in this bill. One look at the cosponsor list should indicate that.

Instead, what we have is a bill that targets a specific legislative goal, to protect bears from illegal and inhumane poaching and black market profiteering. By carefully crafting this legislation with that single goal in mind, we have an opportunity to pass a common sense bill that is supported by wildlife enthusiasts and conservationists while protecting the autonomy of states and the rights of sportsmen.

I continue to believe that these types of targeted, bipartisan conservation efforts that are rooted in consensus goals, rather than conflicting politics, can, in the end, make the most noticeable strides toward protecting our national wildlife and environmental treasures.

I ask unanimous consent that the text of the bill be printed in the RECORD, and I further ask unanimous consent that the RECORD include letters of support from the Humane Society of the United States, the Society for Animal Protective Legislation, and the American Zoo and Aquarium Association.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 1125

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Bear Protection Act of 2001''.

**SEC. 2. FINDINGS.**

Congress finds that—

(1) all 8 extant species of bear—Asian black bear, brown bear, polar bear, American black bear, spectacled bear, giant panda, sun bear, and sloth bear—are listed on Appendix I or II of the Convention on International Trade in Endangered Species of Wild Fauna and Flora (27 UST 1087; TIAS 8249);

(2)(A) Article XIV of CITES provides that Parties to CITES may adopt stricter domestic measures regarding the conditions for trade, taking, possession, or transport of species listed on Appendix I or II; and

(B) the Parties to CITES adopted a resolution in 1997 (Conf. 10.8) urging the Parties to take immediate action to demonstrably reduce the illegal trade in bear parts;

(3)(A) thousands of bears in Asia are cruelly confined in small cages to be milked for their bile; and

(B) the wild Asian bear population has declined significantly in recent years as a result of habitat loss and poaching due to a strong demand for bear viscera used in traditional medicines and cosmetics;

(4) Federal and State undercover operations have revealed that American bears have been poached for their viscera;

(5) while most American black bear populations are generally stable or increasing, commercial trade could stimulate poaching and threaten certain populations if the demand for bear viscera increases; and

(6) prohibitions against the importation into the United States and exportation from the United States, as well as prohibitions against the interstate trade, of bear viscera and products containing, or labeled or advertised as containing, bear viscera will assist in ensuring that the United States does not contribute to the decline of any bear population as a result of the commercial trade in bear viscera.

**SEC. 3. PURPOSES.**

The purpose of this Act is to ensure the long-term viability of the world's 8 bear species by—

(1) prohibiting interstate and international trade in bear viscera and products containing, or labeled or advertised as containing, bear viscera;

(2) encouraging bilateral and multilateral efforts to eliminate such trade; and

(3) ensuring that adequate Federal legislation exists with respect to domestic trade in bear viscera and products containing, or labeled or advertised as containing, bear viscera.

**SEC. 4. DEFINITIONS.**

In this Act:

(1) BEAR VISCERA.—The term ''bear viscera'' means the body fluids or internal organs, including the gallbladder and its contents but not including the blood or brains, of a species of bear.

(2) CITES.—The term ''CITES'' means the Convention on International Trade in Endangered Species of Wild Fauna and Flora (27 UST 1087; TIAS 8249).

(3) IMPORT.—The term ''import'' means to land on, bring into, or introduce into any place subject to the jurisdiction of the United States, regardless of whether the landing, bringing, or introduction constitutes an importation within the meaning of the customs laws of the United States.

(4) PERSON.—The term ''person'' means—

(A) an individual, corporation, partnership, trust, association, or other private entity;

(B) an officer, employee, agent, department, or instrumentality of—

(i) the Federal Government;

(ii) any State or political subdivision of a State; or

(iii) any foreign government; and

(C) any other entity subject to the jurisdiction of the United States.

(5) SECRETARY.—The term ''Secretary'' means the Secretary of the Interior.

(6) STATE.—The term ''State'' means a State, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, American Samoa, and any other territory, commonwealth, or possession of the United States.

(7) TRANSPORT.—The term ''transport'' means to move, convey, carry, or ship by any means, or to deliver or receive for the purpose of movement, conveyance, carriage, or shipment.

**SEC. 5. PROHIBITED ACTS.**

(a) IN GENERAL.—Except as provided in subsection (b), a person shall not—

(1) import into, or export from, the United States bear viscera or any product, item, or substance containing, or labeled or advertised as containing, bear viscera; or

(2) sell or barter, offer to sell or barter, purchase, possess, transport, deliver, or receive, in interstate or foreign commerce, bear viscera or any product, item, or substance containing, or labeled or advertised as containing, bear viscera.

(b) EXCEPTION FOR WILDLIFE LAW ENFORCEMENT PURPOSES.—A person described in section 4(4)(B) may import into, or export from, the United States, or transport between States, bear viscera or any product, item, or substance containing, or labeled or advertised as containing, bear viscera if the importation, exportation, or transportation—

(1) is solely for the purpose of enforcing laws relating to the protection of wildlife; and

(2) is authorized by a valid permit issued under Appendix I or II of CITES, in any case in which such a permit is required under CITES.

**SEC. 6. PENALTIES AND ENFORCEMENT.**

(a) CRIMINAL PENALTIES.—A person that knowingly violates section 5 shall be fined under title 18, United States Code, imprisoned not more than 1 year, or both.

(b) CIVIL PENALTIES.—

(1) AMOUNT.—A person that knowingly violates section 5 may be assessed a civil penalty by the Secretary of not more than $25,000 for each violation.

(2) MANNER OF ASSESSMENT AND COLLECTION.—A civil penalty under this subsection shall be assessed, and may be collected, in the manner in which a civil penalty under the Endangered Species Act of 1973 may be assessed and collected under section 11(a) of that Act (16 U.S.C. 1540(a)).

(c) SEIZURE AND FORFEITURE.—Any bear viscera or any product, item, or substance imported, exported, sold, bartered, attempted to be imported, exported, sold, or bartered, offered for sale or barter, purchased, possessed, transported, delivered, or received in violation of this section (including any regulation issued under this section) shall be seized and forfeited to the United States.

(d) REGULATIONS.—After consultation with the Secretary of the Treasury and the United States Trade Representative, the Secretary shall issue such regulations as are necessary to carry out this section.

(e) ENFORCEMENT.—The Secretary, the Secretary of the Treasury, and the Secretary of the department in which the Coast Guard is operating shall enforce this section in the manner in which the Secretaries carry out enforcement activities under section 11(e) of the Endangered Species Act of 1973 (16 U.S.C. 1540(e)).

(f) USE OF PENALTY AMOUNTS.—Amounts received as penalties, fines, or forfeiture of property under this section shall be used in accordance with section 6(d) of the Lacey Act Amendments of 1981 (16 U.S.C. 3375(d)).

**SEC. 7. DISCUSSIONS CONCERNING BEAR CONSERVATION AND THE BEAR PARTS TRADE.**

In order to seek to establish coordinated efforts with other countries to protect bears, the Secretary shall continue discussions concerning trade in bear viscera with—

(1) the appropriate representatives of Parties to CITES; and

(2) the appropriate representatives of countries that are not parties to CITES and that are determined by the Secretary and the United States Trade Representative to be the leading importers, exporters, or consumers of bear viscera.

**SEC. 8. CERTAIN RIGHTS NOT AFFECTED.**

Except as provided in section 5, nothing in this Act affects—

(1) the regulation by any State of the bear population of the State; or

(2) any hunting of bears that is lawful under applicable State law (including regulations).

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## HSUS STATEMENT IN SUPPORT OF THE BEAR PROTECTION ACT

The Humane Society of the United States, the nation's largest animal protection organization with over seven million members and constituents, strongly supports Senator McConnell's Bear Protection Act.

The Bear Protection Act would eliminate the patchwork of state laws in the U.S. and improve protection of America's bears. Thirty-four states already ban commerce in bear viscera. The remaining states fall into three categories: six allow trade in gallbladders taken from bears legally killed in-state; eight allow trade in gallbladders from bears killed legally outside the state; and two states do not have pertinent laws. This current patchwork of state laws creates loopholes that are exploited by those engaged in the bear parts trade. The loopholes enable poachers to launder gallbladders through states that permit their sale. The Bear Protection Act would eliminate this patchwork of state laws, replacing it with one national law prohibiting import, export, and interstate commerce in bear viscera.

Bear viscera, particularly the gallbladder and bile, have been traditionally used in Asian medicines to treat a variety of illnesses, from diabetes to heart disease. Today, bear viscera is also used in cosmetics and shampoos. Asian demand for bear viscera and products has increased with growing human populations and increased wealth. Bear gallbladders in South Korea are worth more than their weight in gold, potentially yielding a price of about $10,000 each.

While demand for bear viscera and products has grown, Asian bear populations have dwindled. Seven of the eight extant species of bears are threatened by poaching to supply the increasing market demand for bear viscera and products. Most species of bears, and all Asian bear species, are afforded the highest level of protection under the Convention on International Trade in Endangered Species of Wild Fauna and Flora (CITES). CITES has noted that the continued illegal trade in bear parts and derivatives of bear parts undermines the effectiveness of the Convention and that if CITES parties do not take action to eliminate such trade, poaching may cause declines of wild bears that could lead to the extirpation of certain populations or even species.

Dwindling Asian bear populations have caused poachers to look to American bears to meet market demand for bear parts and products. While each year nearly 40,000 American black bears are legally hunted in thirty-six states and Canada, it is estimated that roughly the same number are illegally poached each year, according to a former chief law enforcement officer with the U.S. Fish and Wildlife Service.

The U.S. Senate passed this legislation in the 106th Congress and we hope swift action will be taken again this year. We also hope that the House will follow the Senate's wise lead and act to protect bears across the globe before it's too late. The Humane Society of the United States applauds Senator McConnell and the quarter of the United States Senate that has signed onto the Bear Protection Act as original cosponsors. With Senator McConnell's leadership, there may come a day when bear poachers and bear parts profiteers no longer are able to ply their cruel trade unpunished.

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## BEAR PROTECTION ACT IS URGENTLY NEEDED

The Society for Animal Protective Legislation strongly supports Senator Mitch McConnell in his effort to pass the Bear Protection Act once again. This bill would end the United States' involvement in the trade of bear viscera by prohibiting the import, export and interstate commerce in bear gallbladders and bile. Bears are targeted for their internal organs, which fetch enormous profits for the poachers who illegally kill them and the merchants who sell their organs for use in traditional medicine remedies.

The insatiable, growing demand for bear viscera contributed mightily to the decimation of the Asiatic black bear and may do the same to the stable population of American black bears if a law is not passed to eliminate the United States' role in supplying this devastating bear parts trade.

There is a price on the head of every bear in this country and Senator Mitch McConnell deserves high praise for introducing proactive legislation protecting bears from the looming threat of the gallbladder trade.

The current patchwork of state laws addressing the trade in bear gallbladders and bile allows an illegal trade to flourish. It is impossible to distinguish visually the dissociated gallbladder of one state's black bear from another. This enables smugglers to acquire gallbladders illegally in one state, transport them to a state where commercialization of bear parts is legal, and sell the gallbladders under false pretenses. These gallbladders are also smuggled out of the country, providing a laundering opportunity for the sale of gallbladders from highly endangered bears.

Enactment of Senator McConnell's Bear Protection Act will ensure that those who seek to profit by the reckless destruction of America's bears can be punished appropriately for their illegal and immoral activity.

Mr. McConnell's bill does not impact a state's ability to manage its resident bear population or a lawful hunter's ability to hunt bears in accordance with applicable state laws and regulations. The Bear Protection Act is not about bear hunting—it's about ending bear poaching. This is a laudable goal that all Americans should support.

American citizens should not sit by helplessly while bears are slaughtered, their gallbladders ripped out and the carcass unceremoniously left to rot. It's time to take a stand against bear poachers and profiteers. Congratulations to Senator McConnell for taking up the charge.

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AMERICAN ZOO AND AQUARIUM ASSOCIATION,
*Silver Spring, MD, June 26, 2001.*

Hon. MITCH MCCONNELL,
*U.S. Senate,*
*Washington, DC.*

DEAR SENATOR MCCONNELL: I am writing on behalf of the 196 accredited members of the American Zoo and Aquarium Association (AZA) in support of your proposed Bear Protection Act of 2001.

AZA institutions draw over 135 million visitors annually and have more than 5 million zoo and aquarium members who provide almost $100 million in support. Collectively, these institutions teach more than 12 million people each year in living classrooms, dedicate over $50 million annually to education programs, invest over $50 million annually to scientific research and support over 1,300 field conservation and research projects in 80 countries.

In addition, AZA member institutions have established the Species Survival Plan (SSP) program—a long-term plan involving genetically-diverse breeding, habitat preservation, public education, field conservation and supportive research to ensure survival for many threatened and endangered species. Currently, AZA member institutions are involved in 96 different SSP programs throughout the world, including four species of bear—sloth, sun, spectacled and the giant panda.

It is in this context that AZA expresses its support for the Bear Protection Act. There is little question that most populations of the world's eight bear species have experienced significant declines during this century, particularly in parts of Europe and Asia. Habitat loss has been the major reason for this decline, although overhunting and poaching have also been factors in some cases, especially in Asia. In recent years, the commercial trade of bear body parts, in particular gallbladders and bile, for use in traditional Asian medicines has been implicated as the driving force behind the illegal hunting of some bear populations. Analyses by the US Fish and Wildlife Service (USFWS), TRAFFIC and other organizations have documented the existence of illicit commercial markets and smuggling rings for bear body parts.

Recent information suggests that this is not only an overseas issue but a domestic one as well. The American black bear is listed on Appendix II of CITES due to the similarity of appearance to other listed bear species, and conservation and management of black bear populations remains largely in the hands of the states. Most states prohibit commercial trade in bear parts but there are some states that still allow commercial trade of products from bears taken within their borders. Several other states do not explicitly prohibit the commercial trade in parts from bears taken within the borders of other jurisdictions. This has raised concerns that inconsistent state laws may facilitate illegal trade and laundering of bear parts.

The relatively high value of the wild bear parts, particularly viscera, on the international market warrants that continued action be taken to minimize the threat or potential threat of illegal trade. Your bill provides the necessary first step for closing the potential loopholes that are afforded to bear poachers and dealers by fragmented state laws. Equally important, the bill encourages dialogue between the U.S. and countries known to be leading importers, exporters, and consumers of bear viscera in an attempt to coordinate efforts to protect threatened and endangered bear populations worldwide.

AZA applauds your efforts in this important wildlife conservation matter. In addition, AZA stands ready to work with you to ensure that the necessary funds are authorized and appropriate for the effective administration and enforcement of this critical work.

Please feel free to contact AZA if you have any question or comments.

Regards,

SYDNEY J. BUTLER,
*Executive Director.*

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By Mr. BROWNBACK (for himself and Mr. ENZI):

S. 1126. A bill to facilitate the deployment of broadband telecommunications services, and for other purposes; to the Committee on Commerce, Science, and Transportation.

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By Mr. BROWNBACK (for himself and Mr. ENZI):

S. 1127. A bill to stimulate the deployment of advanced telecommunications services in rural areas, and for other purposes; to the Committee on Commerce, Science, and Transportation.

Mr. BROWNBACK. Mr. President, next week our nation will celebrate Independence Day. Yet, as we celebrate the land of opportunity that is America, we must keep in mind those who, even in this great nation, do not have the same opportunities as everyone else. In rural communities across the nation, an entire segment of our population does not have the opportunity to access powerful broadband communications services representing the high-speed, high-capacity on-ramps to the information super highway. Why? Because for all intents and purposes broadband does not exist in most of rural America.

Broadband is increasing the speeds and capacity with which consumers and businesses alike access the Internet, and opening up a whole new world of information, e-commerce, real-time high quality telemedicine, distance learning, and entertainment. The power of broadband will level the playing field between rural and urban communities in a global economy.

Today I rise to introduce the Rural Broadband Deployment Act of 2001 and the Broadband Deployment and Competition Enhancement Act of 2001. Two bills designed to ensure that all Americans have access to the advantages of broadband connections. I would like to thank my colleague from Wyoming, Senator ENZI, for his cosponsorship and support. These two bills, together or individually, will ensure broadband deployment in our nation's rural areas, and will enable us to renew our long-standing commitment that rural communities have access to the same telecommunications resources as urban communities.

My singular objective, in both bills, is high-speed Internet access for everybody in America by 2007.

This is a bipartisan objective. The Democratic party has announced its intention to ensure universal access to broadband by the end of this decade. I commend my colleagues on the other side of the aisle for their recognition of the importance of broadband and I look forward to working with them to achieve our common goal.

New approaches will be needed to achieve universal broadband availability. Some of my colleagues have introduced legislation consisting of tax incentives or loan subsidies. Programs such as these can help to deliver on the commitment to make broadband universally available, but these proposals alone will not achieve that goal. Deregulation has a key role to play in this effort.

Deregulation has been the driver of broadband deployment to date: cable companies, largely deregulated by the 1996 Telecommunications Act, have invested almost 50 billion dollars in upgrades to their networks. These upgrades have in turn enabled them to deploy broadband, and cable companies now serve 70 percent of the broadband market. Satellite companies, also unregulated in the broadband market, are deploying one-way high-speed Internet access and are working to deploy two-way broadband services. Some companies are utilizing wireless cable licenses to deploy broadband, and they too are unregulated in the broadband market.

Deregulation is a powerful motivator for the deployment of new technologies and services. Unregulated small cable companies, and all but unregulated rural and small telephone companies are taking advantage of their regulatory status to deliver broadband to rural consumers.

The broadband market, distinct from the local telephone market, is new. Yet, federal and State regulators are placing local telephone competition regulations on broadband-specific facilities deployed by incumbent local exchange carriers, ILECs, the only regulated broadband service providers, as if they were part and parcel of their local telephone service. This is simply not the case. The local telephone market is not synonymous with the broadband market. The disparate regulatory treatment of phone companies deploying broadband and all other broadband service providers is serving to deny broadband to many rural communities.

Broadband facilities being deployed by ILECs throughout our cities and towns require billions of dollars of capital investment in new infrastructure that must be added to the existing telephone network. The sparse populations of rural communities already diminish

the return on infrastructure investment so that, when combined with local telephone market regulations, ILEC broadband deployment has not proven to be cost effective.

As a result, rural telephone exchanges owned by regulated telephone companies are not being upgraded for broadband services even while unregulated companies seem to be capable of making that substantial investment. In Wellington, Kansas, a rural community with around 10,000 residents, a small unregulated cable company called Sumner Cable has deployed broadband service. Yet, Southwestern Bell, the local regulated telephone company and a Bell operating company, is not deploying broadband. Different regulatory treatments of these companies creates the incentive for one to deploy broadband, but not the other. This is being seen throughout our nation's rural communities, and is particularly disappointing. The Bell operating companies serve approximately 65 percent of rural telephone lines like those found in Wellington.

Broadband is certainly being deployed at a much faster rate in urban markets than rural markets. But that does not mean all is well in our nation's cities. Today, broadband deployment in urban markets is being characterized by the market dominance of the cable TV industry, unregulated in the broadband market, which serves approximately 70 percent of all broadband subscribers. This is good for consumers. Cable companies have taken full advantage of their deregulated status, and the inherent economic incentives, to deploy new technologies and provide new services to consumers. But while the cable industry finishes rebuilding its entire infrastructure with digital technology that permits it to offer broadband, ILECs are, in many instances, not making the same investment to rebuild their infrastructure.

The Broadband Deployment and Competition Enhancement Act of 2001 promotes broadband deployment in rural markets by requiring ILECs to deploy to all of their telephone exchange subscribers within 5 years. In exchange, ILEC broadband services are placed on a more level-playing field with their broadband competitors. This is achieved by deregulating only those new technologies added to the local telephone network that make broadband possible over telephone lines. By permitting ILECs to compete on a level playing field with their broadband competitors in their urban markets, we can create the proper balance between requirements and incentives.

The limited deregulation in this legislation will not affect competition in the local telephone market. CLECs will still have access to the entire legacy telephone network to use as they see fit, and they will still be permitted to combine their own broadband equipment with the telephone network to compete in the broadband market. In those parts of the local telephone network where new network architecture must be deployed to make broadband possible, CLECs are free to add their own facilities to the network so they can compete for every potential broadband subscriber in a market.

In Kansas, we have many farms and small rural communities. I grew up on a farm near Parker, Kansas. My hometown has 250 people. My singular goal in introducing this legislation is to facilitate rural broadband deployment. Given the importance of ensuring broadband is deployed in rural communities, I have elected to introduce two different bills on the same issue. I am willing to pursue either approach depending on which one will get us to the day of ubiquitous broadband.

It seems clear that, no matter how worthy broad-based deregulation is in the broadband market, any such effort must navigate through the typical back and forth between the baby Bells, long distance companies, and now CLECs. If a more limited approach can avoid the traditional ''phone wars'' then I am happy to put forth such an alternative.

The Rural Broadband Deployment Act of 2001 is a more geographically limited approach to spurring broadband deployment. It includes broader deregulation of ILEC broadband services, but limits that deregulation only to rural communities. By ramping up the deregulation, yet restricting the size of the market where that deregulation is applied, it is my intention to create the same balance of requirements that I previously mentioned.

I realize that introducing two pieces of legislation on the same issue on the same day is a bit unorthodox. But given the clear need and importance of universal broadband, I feel it is my duty to do anything I can to move this debate forward. Providing alternatives for the consideration of my colleagues is part of this process.

I urge my colleagues to give consideration to either of these bills, and I urge your cosponsorship.

Mr. ENZI. Mr. President, I rise as an original cosponsor of Senator BROWNBACK's Broadband Deployment and Competition Enhancement Act of 2001. I thank my colleague from Kansas for drafting this innovative legislation to help solve the problem of the lack of availability of advanced telecommunications services in rural areas.

Telecommunications has come a long way from the days of the party line and operator assisted calls. Telecommunications services have allowed entrepreneurs to locate their business anywhere they can get a dial tone and have helped to bring jobs to rural America. I have been working to encourage more infrastructure development as a way of creating a business environment that will attract new jobs to the places that need them.

The 20th Century has seen the economy of the United States and the world change from an industrial economy to an information economy. We are only at the beginning of the ''Information Revolution'' and now is the best time for private industry and government to take a pro-active role in helping to create the business and regulatory conditions necessary to encourage the widespread deployment of advanced telecommunications services.

Since 1995, the State of Wyoming has been attempting to create a competitive local phone market that would have a multitude of competitors and result in lower rates. The cost of providing service in Wyoming is significantly higher than in other areas of the Nation due to our low population and long distances between towns. This has caused many companies to pass Wyoming by in search of easier profits in urban areas and leave many of our towns with only one choice for broadband service, if they have a provider at all.

One of the reasons why advanced services have been slowly deployed is that Wyoming's wide open spaces make the telecommunications needs of our residents very different than people in urban areas. The economic model of the industry is to serve areas with a high population density in order to keep costs low. In the West, it's harder to make that model work, but the independent telephone companies, Qwest and the cable companies are working hard to offer their customers a full complement of services at a reasonable price, many services that urban telephone customers take for granted.

High speed Internet access has been delayed for two reasons, cost and availability. Advanced telecommunications services can help to build Wyoming's economy. Companies are beginning to realize that our State has a ready work force and the lower costs of doing business are making companies choose Wyoming. Many existing businesses are taking advantage of the Internet to bring their products and services to the world. Where once a store was limited to only being able to serve those within driving distance of it, now it can bring Wyoming to the world. This cannot take place without the continued roll out of broadband business services.

Wyoming has for many years been promoting the benefits of telecommuting. People living around the State have been able to connect to their office via computer and remain in contact with clients. Telecommuting now requires high speed access and that is available in some limited areas. In other areas, the only data access is via a regular dial-up modem. There are companies that are deploying digital subscriber lines and cable modems, but those locations are limited and the price is too high to be adopted by a majority of Wyoming residents. Over time that price will come down, but this is not a call for public subsidies or government mandates, but a call for more competition and deregulation. Competition will bring lower prices and

greater deployment of services to even the smallest of towns.

That is why I am an original cosponsor of Senator BROWNBACK's bill. His bill creates a deregulatory regime that is backed by specific performance requirements and strong enforcement provisions.

The bill requires Incumbent Local Exchange Carriers, ILEC's, to be able to provide advanced services to all of its customers within 5 years of the enactment of this legislation in order to receive the benefits of deregulation. This ensures that companies will bring advanced services and competition to rural areas by giving a hard deadline for companies to complete their buildout.

Advanced services would be deregulated by exempting them from the requirements that ILECs make packet switching and fiber available to competitors at below cost rates. This would specifically deregulate the equipment that makes it possible to provide advanced services over traditional phone lines. The bill also exempts fiber optic lines owned by ILECs from below cost pricing if the fiber is deployed either to the home or in areas that never had telephone infrastructure before. I believe that this will be key to making the economics of rural advanced services more favorable for companies wanting to invest in rural broadband deployment.

The bill would also give ILECs the necessary pricing flexibility for their broadband services. I believe that we should not hamstring a new technology in a very competitive marketplace with outdated regulations on price. It is important that Congress ensure that in addition to the wholesale pricing relief contained in this legislation, it also includes retail pricing flexibility to further make the economics more favorable.

The bill does not change the requirements that ILECs allow competitors to collocate their equipment in an ILEC facility. Collocation is very important since it ensures that competitors have access to the network and do not have to build distant links or other connections to the ILEC network.

The bill also does not eliminate the requirement that ILECs give competitors access to local loops. In fact, if an ILEC does not grant a competitor access to local lines the bill gives state regulators the right to strip the ILEC of the deregulatory benefits contained in the bill.

The bill's enforcement provisions are very strong and explicit. If a company does not meet the build-out requirement, does not permit a competitor to collocate and/or grant competitors access to local loops, state regulators have the authority to return an ILEC to the old regulatory regime. Deregulation without proper enforcement mechanisms does not benefit consumers and competitors. It is important that we hold ILECs accountable if they are granted relief from the pricing requirements.

I have been working with my colleagues to create a mix of deregulation and incentives to encourage private infrastructure development. Government cannot force private firms to make unprofitable investments, but government can work to make investments in rural infrastructure more favorable. The Broadband Deployment and Competition Investment Act helps to make investment in advanced services in rural areas possible.

The great strides made by both Qwest, the smaller phone companies and the cooperatives show that rural areas can support fiber optic based services. The Wyoming Equality Network, the fiber based network linking all of Wyoming's high schools, has been a great advancement for education and I applaud the State's foresight for undertaking such a far reaching project. The WEN has had the added effect of showing other companies that it is possible to link rural areas with fiber, bringing high speed data services and other advanced services to homes and businesses.

I am pleased to see that Qwest and several smaller companies have worked together to close the inter-office fiber loop, linking all local phone exchanges with a fiber optic connection. This will allow for greater capacity and new services like DSL and other high speed broadband services. This connection will help many areas of Wyoming overcome many of the service problems they have been experiencing for the last several years.

The objective of telecommunications policy should be to bring as many players into the marketplace and allow them to compete in the marketplace. Congress should not tie a company's hands in a continually changing and competitive marketplace. We should ensure that all parties are on a level playing field and that all services are regulated in the same manner regardless of the company that is offering the service or the technology they are using. This legislation will help bring some needed consistancy to the regulation of advanced services and I urge my colleagues to support this vital legislation.

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By Mr. WARNER:

S. 1129. A bill to increase the rate of pay for certain offices and positions within the executive and judicial branches of the Government, respectively, and for other purposes; to the Committee on Governmental Affairs.

Mr. WARNER. Mr. President, I am pleased to introduce legislation today to provide relief from the pay compression affecting career Federal employees serving in the Senior Executive Service, SES. It is nearing a decade since Senior Executive Service members have seen a meaningful adjustment in pay.

The salaries earned by these employees are, on average, well below those earned by their peers in private industry. Pay caps for the Senior Executive Service and certain other positions in the government are tied to the Executive Schedule which includes senior level officials as well as Members. Pay freezes for positions on the Executive Schedule in five of the past eight years has resulted in pay compression so severe that 60 percent of the entire executive corps earns essentially the same salary despite differences in obligation and executive level. Over the past eight years, pay increases for these executives would average 1 percent per year. There is not much of an incentive to accept a higher position with added responsibilities and increased work hours for little or no increase in pay.

Many senior executives leave Federal service to begin second careers in the private sector because of the salary compression. Others find that retirement is a more sensible option, whereas Federal annuitants receive an average two and a half percent cost of living adjustment every year compared to the average one percent per year pay increase a senior executive may receive if she or he remained in Federal service.

I have heard from many SES employees relating their own stories as to how the problem of pay compression has affected them. I would like to share a few of these personal accounts.

From an ES–6 with the Department of Defense: ''My pay has been capped and I have not been receiving raises. This year I received a surprise. I turned 55 and I subsequently experienced a $115.16 decrease in pay in January because my life insurance increased considerably, along with the contribution to retirement increase. Age 55 is not old! I expect to work a few more years and I expect my pay to increase so that I can enjoy my retired years with a reasonable retirement income that has not been eroded by the pay cap.''

A Senior Executive at the Department of Health and Human Services: ''The highest career Deputy General Counsel position in my agency became vacant, and I was called by the General Counsel to seriously consider taking it. Aside from the many family issues involved in any move to Washington, an overriding aspect is the fact that I am already at the pay cap. Thus, a move into a position with more responsibility would provide no financial incentive. Although I'm obviously not in government serve for any huge financial rewards, I don't want to go backward financially. Thus, I have decided to forgo this very challenging opportunity that would be a fitting pinnacle to my career with the Federal Government.''

Private Contractor, Department of Defense: ''I turned down a job at the US Nuclear Command and Control System Support Staff, where I'd been stationed on active duty as a Regular Air Force Officer. I retired from the NSS four years ago after over 23 years in the Air Force, and was honored to get offered a Civil Service position back at the office. Instead, I reluctantly turned

down the job. The reason was primarily monetary. In order to take the job, it would have been necessary to give up part of my Air Force retirement pay because I retired as a regular officer. To make matters worse, my pay would have been capped. The bottom line is I would have taken a pay cut with no prospect of a pay raise in the foreseeable future. My family and I were asked to sacrifice pay and time together which we willingly did for over 23 years. Instead, I'm supporting the government in the role of a private sector contractor, where I'm fairly compensated for my expertise.''

These are just a few examples which illustrate how the freeze on executive pay and resulting pay compression have seriously eroded the government's ability to attract and retain the most highly-competent career executives. This is a very timely issue for the Federal Government, seventy percent of the SES corps is eligible to retire over the next four years and almost half are expected to retire upon eligibility. Agencies are being forced to make special requests to increase salaries for their managers and supervisors. They recognize that when someone leaves Federal service, their knowledge and experience goes with them.

The legislation I am introducing increases base pay for Senior Executives from Executive Level IV to Executive Level III, extends locality pay to the Executive Schedule, increases the locality cap from Executive Level III to Executive Level III plus locality pay, and increases the overall limit on compensation that can be received in a single year by career executives from Executive Level I to the Vice-Presidential level. The bill also includes certain positions in the Federal judiciary which have been impacted by the pay caps. The actual raises career executives would receive would continue to be determined at the President's discretion.

The legislation does not, in and of itself, raise senior executive pay and does not increase the salaries of Members of Congress.

It is also my intention to ensure that this issue remains a priority for the incoming Director at the Office of Personnel Management. During the confirmation hearing before the Senate Governmental Affairs Committee last week for Mrs. Kay Coles James, President Bush's nominee to head the Office of Personnel Management, Mrs. James indicated her willingness to work with Members to address the problem of pay compression.

Pay compression within the Senior Executives Service is one of the more pressing issues facing the Federal employee workforce and must be addressed as the situation will only get worse. The only means to alleviate pay compression for the Senior Executives at this time is through legislation. Therefore, I encourage my Senate colleagues to support the bill.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1129

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. PROVISIONS RELATING TO CERTAIN OFFICES AND POSITIONS WITHIN THE EXECUTIVE BRANCH.**

(a) EXECUTIVE SCHEDULE PAY RATES.—

(1) IN GENERAL.—Section 5318 of title 5, United States Code, is amended—

(A) by redesignating subsection (a) as subsection (a)(1) and subsection (b) as paragraph (2); and

(B) by adding at the end the following:

''(b)(1)(A) Effective at the beginning of the first applicable pay period commencing on or after the first day of the month in which any comparability payment becomes payable under section 5304 or 5304a with respect to General Schedule employees within the District of Columbia during any year, the annual rate of pay for positions at each level of the Executive Schedule (exclusive of any previous adjustment under this subsection) shall be adjusted by an amount, rounded to the nearest multiple of $100 (or if midway between multiples of $100, to the next highest multiple of $100) equal to the percentage of such annual rate of pay which corresponds to the percentage adjustment becoming so payable with respect to General Schedule employees within the District of Columbia under such section 5304 or 5304a (as applicable).

''(B) If an adjustment under this subsection is scheduled to take effect on the same date as an adjustment under subsection (a), the adjustment under subsection (a) shall be made first.

''(2) An annual rate of pay, as adjusted under paragraph (1), shall for all purposes be treated as the annual rate of pay for the positions involved, except as otherwise provided in subsection (a), paragraph (1), or any other provision of law.

''(3) Nothing in this subsection shall be considered to permit or require the continuation of an adjustment under paragraph (1) after the comparability payment (for General Schedule employees within the District of Columbia) on which it was based has been terminated or superseded.''.

(2) CONTRACT APPEALS BOARD MEMBERS.—Section 5372a of title 5, United States Code, is amended—

(A) in subsection (b)(2) by striking ''97 percent of the rate under paragraph (1)'' and inserting ''no less than 97 percent of the rate under paragraph (1)'';

(B) in subsection (b)(3) by striking ''94 percent of the rate under paragraph (1)'' and inserting ''no less than 94 percent of the rate under paragraph (1)''; and

(C) by adding at the end the following:

''(d) Subject to subsection (b), effective at the beginning of the first applicable pay period commencing on or after the first day of the month in which an adjustment takes effect under section 5303 in the rates of basic pay under the General Schedule, each rate of basic pay for contract appeals board members shall be adjusted by an amount determined by the President to be appropriate.''.

(3) CONFORMING AMENDMENTS.—Section 5318 of title 5, United States Code, is amended—

(A) in the first sentence of subsection (a)(1) (as redesignated)—

(i) by striking ''Subject to subsection (b),'' and inserting ''Subject to paragraph (2),''; and

(ii) by inserting ''(exclusive of any previous adjustment under subsection (b))'' after ''Executive Schedule''; and

(B) in subsection (a)(2) (as redesignated), by striking ''subsection (a)'' and inserting ''paragraph (1)''.

(b) AMENDMENTS RELATING TO CERTAIN LIMITATION AND OTHER PROVISIONS.—

(1) PROVISIONS TO BE APPLIED BY EXCLUDING EXECUTIVE SCHEDULE COMPARABILITY ADJUSTMENT.—Sections 5303(f), 5304(h)(1)(F), 5306(e), and 5373(a) of title 5, United States Code, are each amended by inserting '', exclusive of any adjustment under section 5318(b)'' after ''Executive Schedule''.

(2) LIMITATION ON CERTAIN PAYMENTS.—Section 5307(a) of title 5, United States Code, is amended by adding at the end the following:

''(3) In the case of an employee who is receiving basic pay under section 5372a, 5376, or 5383, paragraph (1) shall be applied by substituting 'the annual rate of salary of the Vice President of the United States' for 'the annual rate of basic pay payable for level I of the Executive Schedule'. Regulations under subsection (c) may extend the application of the preceding sentence to other equivalent categories of employees.''.

(3) REFERENCES TO LEVEL IV OF THE EXECUTIVE SCHEDULE.—Sections 5372(b)(1)(C), 5372a(b)(1), 5376(b)(1)(B), and 5382(b) of title 5, United States Code, are each amended by striking ''level IV'' each place it appears and inserting ''level III''.

**SEC. 2. PROVISIONS RELATING TO CERTAIN OFFICES AND POSITIONS WITHIN THE JUDICIAL BRANCH.**

(a) INCREASE IN MAXIMUM RATES OF BASIC PAY ALLOWABLE.—

(1) FOR POSITIONS COVERED BY SECTION 604(a)(5) OF TITLE 28, UNITED STATES CODE.—Section 604(a)(5) of title 28, United States Code, is amended by striking ''by law'' and inserting ''by law (except that the rate of basic pay fixed under this paragraph for any such employee may not exceed the rate for level IV of the Executive Schedule)''.

(2) FOR CIRCUIT EXECUTIVES.—Section 332(f)(1) of title 28, United States Code, is amended by striking ''level IV of the Executive Schedule pay rates under section 5315'' and inserting ''level III of the Executive Schedule pay rates under section 5314''.

(3) FOR PERSONNEL OF THE ADMINISTRATIVE OFFICE OF THE UNITED STATES COURTS.—

(A) IN GENERAL.—Section 3(a) of the Administrative Office of the United States Courts Personnel Act of 1990 (28 U.S.C. 602 note) is amended—

(i) in paragraph (1), by striking ''level V'' and inserting ''level IV''; and

(ii) in paragraph (10), by striking ''level IV'' and inserting ''level III''.

(B) PROVISIONS RELATING TO CERTAIN ADDITIONAL POSITIONS.—Section 603 of title 28, United States Code, is amended by striking ''level IV of the Executive Schedule under section 5315'' and inserting ''level III of the Executive Schedule under section 5314''.

(b) SALARY OF THE DIRECTOR OF THE ADMINISTRATIVE OFFICE OF THE UNITED STATES COURTS.—Section 603 of title 28, United States Code, is amended by striking ''district'' and inserting ''circuit''.

**SEC. 3. EFFECTIVE DATE.**

The amendments made by this Act shall be effective with respect to pay periods beginning on or after the date of enactment of this Act.

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By Mr. CRAIG (for himself, Mrs. FEINSTEIN, and Mr. CORZINE):

S. 1130. A bill to require the Secretary of Energy to develop a plan for a magnetic fusion burning plasma experiment for the purpose of accelerating the scientific understanding and development of fusion as a long

term energy source, and for other purposes; to the Committee on Energy and Natural Resources.

Mr. CRAIG. Mr. President, today I am introducing a bill of great significance to our energy future, the Fusion Energy Sciences Act of 2001. I am especially pleased that my colleague from California, Senator FEINSTEIN, is joining me as the primary cosponsor of this legislation. This bill is designed to strengthen the fusion program at the Department of Energy and to accelerate planning for the next major step in fusion energy science development.

In recent months, the news has been dominated by energy concerns. Although there may be differences of opinion about the causes of our current energy problems and what the appropriate solutions might be, there is general agreement that energy forms a vital link to our economic prosperity and provides the means by which the conduct of our daily lives is made easier and more comfortable. While we grapple with short term remedies, we need to stay focused on long term investment in those endeavors which have the potential to help secure our energy future. I believe that fusion energy has this potential.

Fusion is the energy source that powers the sun and the stars. At its most basic, it is the combining or fusion of two small atoms into a larger atom. When two atomic nuclei fuse, tremendous amounts of energy are released.

If we can achieve this joining of atoms, and successfully contain and harness the energy produced, fusion will be close to an ideal energy source. It produces no air pollutants because the byproduct of the reaction is helium, it is safe and its fuel source, hydrogen, is practically unlimited and easily obtained.

In the technical community, the debate over the scientific feasibility of fusion energy is now over. During the past decade, substantial amounts of fusion energy have been created in the laboratory setting. I am proud to note that some of this underlying scientific work has been conducted at the Idaho National Engineering and Environmental Laboratory in my State, which has been selected by the Department of Energy to lead efforts on fusion safety.

Although certain scientific questions remain, the primary outstanding issue about fusion energy at this point is whether fusion energy can make the challenging step from the laboratory into a practical energy resource. Achieving this goal will require high quality science, innovative research and international collaboration, and the resources to make this possible. That is the goal to which this legislation is directed.

According to the scientific experts, the path to practical fusion will involve three steps. First, there is a need to conduct a ''burning plasma'' experiment. Second, this effort would be further developed in an engineering test facility. The third step would be a demonstration plant. If taken in series, each of these steps would take approximately fifteen years, but through international collaboration, it may be possible to accelerate this process. In addition to these steps, continued investment in a strong underlying program of fusion science and plasma physics will still be necessary.

Therefore, this bill instructs the Secretary of Energy to transmit to the Congress by July 1, 2004 a plan for a ''burning plasma'' experiment, which is the next necessary step towards the eventual realization of practical fusion energy. At a minimum, the Secretary must submit a plan for a domestic U.S. experiment, but may also submit a plan for U.S. involvement in an international burning plasma experiment if such involvement is cost effective and has equivalent scientific benefits to a domestic experiment. The bill also requires that within six months of the enactment, the Secretary of Energy shall submit a plan to Congress to ensure a strong scientific base for the fusion energy sciences program. Finally, for ongoing activities in the Department of Energy's fusion energy sciences program and for the purpose of preparing the plans called for, the bill authorizes $320,000,000 in fiscal year 2002 and $335,000,000 in fiscal year 2003.

As we suffer through near term challenges in the energy sector and meeting our immediate needs, it is more crucial than ever that we invest in those items that hold the promise for long term solutions. Recent accomplishments in the laboratory demonstrate that fusion energy has this long term potential. The Fusion Energy Sciences Act of 2001 will bring this promise closer to reality for future generations.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1130

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act my be cited as the ''Fusion Energy Sciences Act of 2001''.

**SEC. 2. FINDINGS.**

The Congress finds that—

(1) economic prosperity is closely linked to an affordable and ample energy supply;

(2) environmental quality is closely linked to energy productions and use;

(3) population, worldwide economic development, energy consumption, and stress on the environment are all expected to increase substantially in the coming decades;

(4) the few energy options with the potential to meet economic and environmental needs for the long-term future must be pursued aggressively now, as part of a balanced national energy plan;

(5) fusion energy is a long-term energy solution that is expected to be environmentally benign, safe, and economical, and to use a fuel source that is practically unlimited;

(6) the National Academy of Sciences, the President's Committee of Advisers on Science and Technology, and the Secretary of Energy Advisory Board have each recently reviewed the Fusion Energy Sciences Program and each strongly supports the fundamental science and creative innovation of the program, and has confirmed that progress toward the goal of producing practical fusion energy has been excellent;

(7) each of these reviews stressed the need for the Fusion Energy Sciences Program to move forward to a magnetic fusion burning plasma experiment, capable of producing substantial fusion power output and providing key information for the advancement of fusion science;

(8) the National Academy of Sciences has also called for a broadening of the Fusion Energy Sciences Program research base as a means to more fully integrate the fusion science community into the broader scientific community; and

(9) the Fusion Energy Sciences Program budget is inadequate to support the necessary science and innovation for the present generation of experiments, and cannot accommodate the cost of a burning plasma experiment constructed by the United States, or even the cost of key participation by the United States in an international effort.

**SEC. 3. PLAN FOR FUSION EXPERIMENT.**

(a) PLAN FOR UNITED STATES FUSION EXPERIMENT.—The Secretary of Energy (in this Act referred to as 'the Secretary'), on the basis of full consultation with, and the recommendation of, the Fusion Energy Sciences Advisory Committee (in this Act referred to as ''FESAC''), shall develop a plan for United States construction of a magnetic fusion burning plasma experiment for the purpose of accelerating scientific understanding of fusion plasmas. The Secretary shall request a review of the plan by the National Academy of Sciences, and shall transmit the plan and the review to the Congress by July 1, 2004.

(b) REQUIREMENTS OF PLAN.—The plan described in subsection (a) shall—

(1) address key burning plasma physics issues; and

(2) include specific information on the scientific capabilities of the proposed experiment, the relevance of these capabilities to the goal of practical fusion energy, and the overall design of the experiment including its estimated cost and potential construction sites.

(c) UNITED STATES PARTICIPATION IN AN INTERNATIONAL EXPERIMENT.—In addition to the plan described in subsection (a), the Secretary, on the basis of full consultation with, and the recommendation of, FESAC, may also develop a plan for United States participation in an international burning plasma experiment for the same purpose, whose construction is found by the Secretary to be highly likely and where United States participation is cost effective relative to the cost and scientific benefits of a domestic experiment described in subsection (a). If the Secretary elects to develop a plan under this subsection, he shall include the information described in subsection (b), and an estimate of the cost of United States participation in such an international experiment. The Secretary shall request a review by the National Academies of Sciences and Engineering of a plan developed under this subsection, and shall transmit the plan and the review to the Congress no later than July 1, 2004.

(d) AUTHORIZATION OF RESEARCH AND DEVELOPMENT.—The Secretary, through the Fusion Energy Sciences Program, may conduct any research and development necessary to fully develop the plans described in this section.

**SEC. 4. PLAN FOR FUSION ENERGY SCIENCES PROGRAM.**

Not later than 6 months after the date of enactment of this Act, the Secretary, in full

consultation with FESAC, shall develop and transmit to the Congress a plan for the purpose of ensuring a strong scientific base for the Fusion Energy Sciences Program and to enable the experiment described in section 3. Such plan shall include as its objectives—

(1) to ensure that existing fusion research facilities and equipment are more fully utilized with appropriate measurements and control tools;

(2) to ensure a strengthened fusion science theory and computational base;

(3) to encourage and ensure that the selection of and funding for new magnetic and inertial fusion research facilities is based on scientific innovation and cost effectiveness;

(4) to improve the communication of scientific results and methods between the fusion science community and the wider scientific community;

(5) to ensure that adequate support is provided to optimize the design of the magnetic fusion burning plasma experiments referred to in section 3; and

(6) to ensure that inertial confinement fusion facilities are utilized to the extent practicable for the purpose of inertial fusion energy research and development.

**SEC. 5. AUTHORIZATION OF APPROPRIATIONS.**

There are authorized to be appropriated to the Secretary for the development and review of the plans described in this Act and for activities of the Fusion Energy Sciences Program $320,000,000 for fiscal year 2002 and $335,000,000 for fiscal year 2003.

Mrs. FEINSTEIN. Mr. President, I rise today to join my colleague, Senator LARRY CRAIG, in introducing this legislation to accelerate the development of fusion energy as a practical and realistic alternative to fossil fuels for our nation's energy needs.

I would also like to commend my colleague, Congresswoman ZOE LOFGREN, who introduced the ''Fusion Energy Sciences Act of 2001'' on the House side as H.R. 1781.

Since the beginning of the Manhattan Project, scientists have been trying to harness energy from fusion to produce electricity. This legislation will help the scientific community expedite the development of fusion as a viable option for our energy needs.

To help fusion science move from the lab to the grid, this bill fast-tracks a key experimental fusion project. This bill also authorizes $320 million for Fiscal Year 2002 and $335 million for Fiscal Year 2003 to speed up fusion's current estimated 45-year implementation timetable.

I have spoken frequently to my colleagues on California's current energy situation.

Last week the Department of Energy predicted the State will suffer from around 110 hours of rolling blackouts this summer. Experts say $21.8 billion of economic output will be lost and over 135,000 workers will lose their jobs because of this summer's blackouts.

I will continue to try to help California and the rest of the West in the short-term. Making rolling blackouts less frequent, lowering electricity costs on the wholesale market, keeping natural gas prices reasonable, and bringing new supplies of power online are the key objectives I have been working toward to bring stability to the Western Energy Market.

While I work on the short-term problems in California, I join my colleague from Idaho on this bill to develop a key long-term solution to our current energy problems.

As world populations grow, and as civilization advances, we need to pursue new energy sources beyond traditional fossil fuels.

It is no secret that fossil fuels are finite and polluting. Beyond expanding renewable energy sources such as those from the sun and the wind, fusion holds a great deal of potential to expand our nation's energy supply.

Fusion is a safe, almost inexhaustible energy source with major environmental advantages. As a co-sponsor of this legislation, I hope to see fusion move quickly from an experiment in the lab to a reality for our homes and businesses.

We have already succeeded in using scientific advancements to harness energy occurring elsewhere on our planet. Solar panels collect the sun's rays to heat pools and power homes. Windmills transfer nature's gusts into electrical currents. Water running from mountaintops to the sea can produce significant amounts of hydroelectric power.

And now, with fusion energy, we will be able to harness the power of the stars to create an almost unlimited and clean form of energy.

Fusion energy is the result of two small hydrogen atoms combining into a larger atom. The energy released from this fusion of the atoms can be harnessed to generate electricity.

Unlike nuclear power, which uses radioactive materials for fuel, fusion uses hydrogen from water. Unlike fossil fuels, which pollute the air when burned, the only byproduct in a hydrogen fusion reaction is helium, an element already plentiful in the air.

Besides being environmentally benign, fusion is a practically unlimited fuel source. In fact, scientists predict that using 1 gallon of sea water, fusion can yield the energy produced from 300 gallons of gasoline. And with fusion, 50 cups of sea water can be the energy equivalent of 2 tons of coal.

Fusion energy has been proven to be a practical energy endeavor, worthy of more investment for research and development. So just where do we go from here? How do we harness the power of the stars?

A 1999 review by the Department of Energy's task force on Fusion Energy concluded: one, substantial scientific progress has been made in the science of fusion energy; two, the budget for fusion research needs to grow; and three, a burning plasma experiment needs to be carried out.

To expedite the use of fusion to meet our energy needs, we need to strengthen the efforts already underway in fusion research and development and create new programs financed by the government.

Scientists agree that at current funding levels, fusion is approximately 45 years away from entering the marketplace as a viable energy source.

This timetable is based upon a three step process in which the scientific community can: first, carry out a burning plasma experiment; second, build a fusion energy test facility; and third, establish a fusion demonstration plant to generate electricity.

Since practical fusion energy generation is still three stages from real implementation, the first thing we can do is fund the development of a burning plasma experiment.

This legislation will ensure this project will happen soon, carried out either by the scientific community in the United States, or in collaboration with an international effort. The bill requires the Secretary of Energy to develop a plan by 2004 for a magnetic fusion burning plasma experiment.

It is important to point out that this bill adds the burning plasma experiment in addition to, and not at the expense of, other ongoing projects.

The goal of fusion energy is to create a continually burning fuel like a fire refueling itself. Developing a magnetic fusion plasma experiment will help the scientific community demonstrate how the heat from the fusion reaction can maintain the reaction as a self-generating fuel. Strong magnetic fields allow the hydrogen plasma to be heated to high temperatures for fusion.

This legislation will help the scientific community overcome the key stumbling block to fusion development. By authorizing $320 million for Fiscal Year 2002 and $335 for Fiscal Year 2003 the fusion plasma experiment will be carried out and fusion funding that peaked in the 1970s, but has since tapered off, will be restored.

Let me just take a moment to mention where this funding is going, because it is particularly important for me to point this out.

Annual Federal funding for fusion energy has averaged around $230 million in the last few years. In Fiscal Year 2001, Congress appropriated $248.49 million for fusion research.

This money has provided approximately 1,100 jobs in California at the following U.S. Fusion Program Participant locations: UC Davis, UC Berkeley, Stanford, UCLA, UC Santa Barbara, Cal Tech, UC San Diego, UC Irvine, Occidental College, Lawrence Livermore National Lab, Sandia National Lab, Stanford Linear Accelerator Center, Lawrence Berkeley National Lab, TSI Research Inc. and General Atomics.

Despite all of the past advancements at these facilities and others, the Fusion Energy Science Advisory Committee has concluded that lack of funding is hindering the technological advance towards fusion energy development. And the Department of Energy's task force on Fusion Energy has concluded that, ''In light of the promise of fusion,'' funding remains ''subcritical.''

Currently, the international community is outpacing us on the road to realizing the myriad benefits of this new energy resource. The Japanese budget for this type of research is about 1.5

times that of the U.S., and the European budget is about 3 times greater.

It is critical that we be the leader in the renewable energy resources sector.

I urge my colleagues to join Senator CRAIG and me in supporting fusion energy as a clean, safe, and abundant energy source for our Nation's long-term energy supply.

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By Mr. LEAHY:

S. 1131. A bill to promote economically sound modernization of electric power generation capacity in the United States, to establish requirements to improve the combustion heat rate efficiency of fossil fuel-fired electric utility generating units, to reduce emissions of mercury, carbon dioxide, nitrogen, oxides, and sulfur dioxide, to require that all fossil fuel-fired electric utility generating units operating in the United States meet new sources review requirements, to promote the use of clean coal technologies, and to promote alternative energy and clean energy sources such as solar, wind, biomass, and fuel cells; to the Committee on Finance.

Mr. LEAHY. Mr. President, the Administration finally released its National Energy Policy last month. As I noted at the time, I have serious concerns about several of its recommendations, not the least of which was its proposal to build 1,300 to 1,900 new electric power plants many of them burning relatively dirty fossil fuels, while, at same time, questioning the enforcement of clean air laws that protect the public from excess power plant emissions.

Today, fossil fuel-fired power plants constitute the largest source of air pollution in the United States. Every year, they collectively emit approximately 2.2 billion tons of carbon dioxide, 13 million tons of acid rain-producing sulfur dioxide, 7 million tons of acid rain- and smog-producing nitrogen oxides, and 43 tons of highly toxic mercury.

How could pollutants still be dumped into our atmosphere at this scale? One reason that cannot be ignored is that more than 75 percent of the fossil-fuel fired power plants in the United States are still ''grandfathered,'' or exempt from modern Clean Air Act standards. When the Clean Air Act and its amendments were passed, Congress assumed that old, 1950's era power plants would be retired over time and replaced by newer, cleaner plants within 30 years. They were not. Unfortunately, utilities have kept these inefficient, pollution-prone power plants on line because they are inexpensive. Those grandfathered plants continue to burn cheap fuel and refuse to invest in emissions control technologies that protect air quality.

The continuing harm to our atmosphere, lands, waters, State economies, and public health by excess power plant emissions is well documented. In my home state of Vermont, acid deposition caused by emissions of sulfur dioxide and nitrogen oxide has scarred our forests and poisoned our streams. Emissions of mercury have contaminated our rivers and lakes to the point that statewide advisories against fish consumption are necessary to protect citizens. Emissions of greenhouse gas threaten to negatively change the climate for Vermont maple trees the source of Vermont maple syrup and other economic Vermont crops. And despite Vermont's tough air laws and small population, out-of-state particulates and smog lower our air quality, endanger our health, and ruin views of our Green Mountains.

Earlier this year, I cosponsored bipartisan legislation, the ''Clean Power Act of 2001,'' that strictly capped national power plant emissions and ended ''grandfather'' loophole exemptions. To promote rapid and reliable changes in the utility industry, that legislation also gave utilities the regulatory tools needed to make those changes with incentives for free market trading of emissions credits, a so-called ''cap-and-trade'' mechanism. I remain a supporter of the Clean Power Act of 2001 and hope it becomes key to energy policy negotiations in Congress. However, I believe we can do even more.

So today I am introducing a second piece of legislation covering power plant emissions that I also intend to promote during the energy debate. The ''Clean Power Plant and Modernization Act of 2001'' again strictly caps emissions and ends the ''grandfather'' loophole on old plants. Instead of providing utilities the incentive of free market trading, however, my bill creates strong financial incentives, in the form of accelerated tax depreciation, for older utilities that cut emissions and upgrade their plants to 45 percent to 50 percent efficiency. With current average energy efficiency of U.S. power plants at only 33 percent, this bill is another proposal that protects the environment and public health while providing the energy industry with a comprehensive and predictable set of long-term regulatory requirements.

Under this bill, mercury emissions would be cut by 90 percent, annual emissions of sulfur dioxide would be cut by more than 6 million tons beyond Phase II Clean Air Act Amendments requirements, and nitrogen oxide emissions would be cut by more than 3 million tons per year beyond Phase II requirements. This bill would also prevent at least 650 million tons of carbon dioxide emissions per year.

And this bill goes beyond emissions caps and transition incentives to recognize the emergence of energy technologies that are more environmentally sustainable. It provides substantial funding for research, development, and commercial demonstrations of renewable and clean energy technologies such as solar, wind, biomass, geothermal, and fuel cells. It also authorizes expenditures for implementing known ways of biologically sequestering carbon dioxide from the atmosphere such as planting trees, preserving wetlands, and soil restoration.

The bill emphasizes the importance of immediately capping, if not totally eliminating, the release of mercury from power plants. In December, the EPA finally determined to regulate mercury emissions from electric utility power plants, an action I strongly commended. However, such regulations are years away, and it is uncertain what form they will take. Yet, just last year, 41 states issued more than 2,200 fish consumption advisories because of mercury contamination. Eleven states, including Vermont, issued statewide advisories. In 2000, the National Academy of Sciences confirmed the health risks of mercury, emphasizing the special vulnerability of unborn and young children. I believe we need to do something now.

As the energy landscape of our nation changes, this bill also recognizes the need to train a new national energy work force. As U.S. power plants become more efficient and more power is produced by renewable technologies, less fossil fuel will be consumed. This will have an impact on the workers and communities that produce fossil fuels. These effects are likely to be greatest for coal, even with significant deployment of clean coal technology. The bill provides funding for programs to help workers and communities during the period of transition. I am eager to work with organized labor to ensure that these provisions address the needs of workers, particularly those who may not fully benefit from retraining programs.

Finally, this bill holds the electric power industry, and Congress, accountable for any and all taxpayer dollars used to aid the transition to cleaner electric generation facilities. To assess how well clean air laws and emissions reductions are working, our nation must have robust, nationwide monitoring networks capable of generating reliable, consistent, long-term data about natural ecosystems. Networks such as the National Atmospheric Deposition Program currently provide the national data needed by scientists and Federal agencies to accurately assess the trends in pollutant deposition. Yet, over the past 30 years, these networks have struggled to survive with ever-decreasing funding. My bill provides modest appropriations for both operational support and modernization of scientific sites that are so critical to understanding of our ecosystems and our public health.

The American public overwhelmingly supports the environmental commitments that we have made since the early 1970s. It is our responsibility to preserve the environment for our children and grandchildren, and it is our duty to protect their health as well. The proposed energy policy of this administration needs to be less about drilling and more about energy efficiency and protection of air quality. This bill will, I hope, add another way

in which we can ensure reliable, affordable electric power while modernizing energy efficiency and protecting our national resources.

I ask unanimous consent that the text of the bill, and the section-by-section overview of the bill be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 1131

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) SHORT TITLE.—This Act may be cited as the ''Clean Power Plant and Modernization Act of 2001''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:



**SEC. 2. FINDINGS AND PURPOSES.**

(a) FINDINGS.—Congress finds that—

(1) the United States is relying increasingly on old, needlessly inefficient, and highly polluting power plants to provide electricity;

(2) the pollution from those power plants causes a wide range of health and environmental damage, including—

(A) fine particulate matter that is associated with the deaths of approximately 50,000 Americans annually;

(B) urban ozone, commonly known as ''smog'', that impairs normal respiratory functions and is of special concern to individuals afflicted with asthma, emphysema, and other respiratory ailments;

(C) rural ozone that obscures visibility and damages forests and wildlife;

(D) acid deposition that damages estuaries, lakes, rivers, and streams (and the plants and animals that depend on them for survival) and leaches heavy metals from the soil;

(E) mercury and heavy metal contamination that renders fish unsafe to eat, with especially serious consequences for pregnant women and their fetuses;

(F) eutrophication of estuaries, lakes, rivers, and streams; and

(G) global climate change that may fundamentally and irreversibly alter human, animal, and plant life;

(3) tax laws and environmental laws—

(A) provide a very strong incentive for electric utilities to keep old, dirty, and inefficient generating units in operation; and

(B) provide a strong disincentive to investing in new, clean, and efficient generating technologies;

(4) fossil fuel-fired power plants, consisting of plants fueled by coal, fuel oil, and natural gas, produce more than two-thirds of the electricity generated in the United States;

(5) since, according to the Department of Energy, the average combustion heat rate efficiency of fossil fuel-fired power plants in the United States is 33 percent, 67 percent of the heat generated by burning the fuel is wasted;

(6) technology exists to increase the combustion heat rate efficiency of coal combustion from 35 percent to 50 percent above current levels, and technological advances are possible that would boost the net combustion heat rate efficiency even more;

(7) coal-fired power plants are the leading source of mercury emissions in the United States, releasing more than 43 tons of this potent neurotoxin each year;

(8) in 1999, fossil fuel-fired power plants in the United States produced nearly 2,200,000,000 tons of carbon dioxide, the primary greenhouse gas;

(9) on average, fossil fuel-fired power plants emit approximately 2,000 pounds of carbon dioxide for every megawatt hour of electricity produced;

(10) the average fossil fuel-fired generating unit in the United States commenced operation in 1964, 6 years before the Clean Air Act (42 U.S.C. 7401 et seq.) was amended to establish requirements for stationary sources;

(11)(A) according to the Department of Energy, only 23 percent of the 1,000 largest emitting units are subject to stringent new source performance standards under section 111 of the Clean Air Act (42 U.S.C. 7411); and

(B) the remaining 77 percent, commonly referred to as ''grandfathered'' power plants, are subject to much less stringent requirements;

(12) according to available scientific and medical evidence, exposure to mercury and mercury compounds is of concern to human health and the environment;

(13) according to the report entitled ''Toxicological Effects of Methylmercury'' and submitted to Congress by the National Academy of Sciences in 2000, and other scientific and medical evidence, pregnant women and their developing fetuses, women of childbearing age, children, and individuals who subsist primarily on fish are most at risk for mercury-related health impacts such as neurotoxicity;

(14) although exposure to mercury and mercury compounds occurs most frequently through consumption of mercury-contaminated fish, such exposure can also occur through—

(A) ingestion of breast milk;

(B) ingestion of drinking water, and foods other than fish, that are contaminated with methylmercury; and

(C) dermal uptake through contact with soil and water;

(15) the report entitled ''Mercury Study Report to Congress'' and submitted by the Environmental Protection Agency under section 112(n)(1)(B) of the Clean Air Act (42 U.S.C. 7412(n)(1)(B)), in conjunction with other scientific knowledge, supports a plausible link between mercury emissions from combustion of coal and other fossil fuels and mercury concentrations in air, soil, water, and sediments;

(16)(A) the Environmental Protection Agency report described in paragraph (15) supports a plausible link between mercury emissions from combustion of coal and other fossil fuels and methylmercury concentrations in freshwater fish;

(B) in 2000, 41 States issued health advisories that warned the public about consuming mercury-tainted fish, as compared to 27 States that issued such advisories in 1993; and

(C) the number of mercury advisories nationwide increased from 899 in 1993 to 2,242 in 2000, an increase of 149 percent;

(17) pollution from power plants can be reduced through adoption of modern technologies and practices, including—

(A) methods of combusting coal that are intrinsically more efficient and less polluting, such as pressurized fluidized bed combustion and an integrated gasification combined cycle system;

(B) methods of combusting cleaner fuels, such as gases from fossil and biological resources and combined cycle turbines;

(C) treating flue gases through application of pollution controls;

(D) methods of extracting energy from natural, renewable resources of energy, such as solar and wind sources;

(E) methods of producing electricity and thermal energy from fuels without conventional combustion, such as fuel cells; and

(F) combined heat and power methods of extracting and using heat that would otherwise be wasted, for the purpose of heating or cooling office buildings, providing steam to processing facilities, or otherwise increasing total efficiency;

(18) adopting the technologies and practices described in paragraph (17) would increase competitiveness and productivity, secure employment, save lives, and preserve the future; and

(19) accurate, long-term, nationwide monitoring of atmospheric acid and mercury deposition is essential for—

(A) determining deposition trends;

(B) evaluating the local and regional transport of emissions; and

(C) assessing the impact of emission reductions.

(b) PURPOSES.—The purposes of this Act are—

(1) to protect and preserve the environment while safeguarding health by ensuring that each fossil fuel-fired generating unit minimizes air pollution to levels that are technologically feasible through modernization and application of pollution controls;

(2) to greatly reduce the quantities of mercury, carbon dioxide, sulfur dioxide, and nitrogen oxides entering the environment from combustion of fossil fuels;

(3) to permanently reduce emissions of those pollutants by increasing the combustion heat rate efficiency of fossil fuel-fired generating units to levels achievable through—

(A) use of commercially available combustion technology, including clean coal technologies such as pressurized fluidized bed combustion and an integrated gasification combined cycle system;

(B) installation of pollution controls;

(C) expanded use of renewable and clean energy sources such as biomass, geothermal, solar, wind, and fuel cells; and

(D) promotion of application of combined heat and power technologies;

(4)(A) to create financial and regulatory incentives to retire thermally inefficient generating units and replace them with new units that employ high-thermal-efficiency combustion technology; and

(B) to increase use of renewable and clean energy sources such as biomass, geothermal, solar, wind, and fuel cells;

(5) to establish the Clean Air Trust Fund to fund the training, economic development, carbon sequestration, and research, development, and demonstration programs established under this Act;

(6) to eliminate the ''grandfather'' loophole in the Clean Air Act relating to sources in operation before the promulgation of standards under section 111 of that Act (42 U.S.C. 7411);

(7) to express the sense of Congress that permanent reductions in emissions of greenhouse gases that are accomplished through the retirement of old units and replacement by new units that meet the combustion heat rate efficiency and emission standards specified in this Act should be credited to the utility sector and the owner or operator in any climate change implementation program;

(8) to promote permanent and safe disposal of mercury recovered through coal cleaning, flue gas control systems, and other methods of mercury pollution control;

(9) to increase public knowledge of the sources of mercury exposure and the threat to public health from mercury, particularly the threat to the health of pregnant women and their fetuses, women of childbearing age, and children;

(10) to decrease significantly the threat to human health and the environment posed by mercury;

(11) to provide worker retraining for workers adversely affected by reduced consumption of coal;

(12) to provide economic development incentives for communities adversely affected by reduced consumption of coal;

(13) to promote research concerning renewable energy sources, clean power generation technologies, and carbon sequestration; and

(14) to promote government accountability for compliance with the Clean Air Act (42 U.S.C. 7401 et seq.) and other emission reduction laws by ensuring accurate, long-term, nationwide monitoring of atmospheric acid and mercury deposition.

**SEC. 3. DEFINITIONS.**

In this Act:

(1) ADMINISTRATOR.—The term ''Administrator'' means the Administrator of the Environmental Protection Agency.

(2) GENERATING UNIT.—The term ''generating unit'' means an electric utility generating unit.

**SEC. 4. COMBUSTION HEAT RATE EFFICIENCY STANDARDS FOR FOSSIL FUEL-FIRED GENERATING UNITS.**

(a) STANDARDS.—

(1) IN GENERAL.—Not later than the day that is 10 years after the date of enactment of this Act, each fossil fuel-fired generating unit that commences operation on or before that day shall achieve and maintain, at all operating levels, a combustion heat rate efficiency of not less than 45 percent (based on the higher heating value of the fuel).

(2) FUTURE GENERATING UNITS.—Each fossil fuel-fired generating unit that commences operation more than 10 years after the date of enactment of this Act shall achieve and maintain, at all operating levels, a combustion heat rate efficiency of not less than 50 percent (based on the higher heating value of the fuel), unless granted a waiver under subsection (d).

(b) TEST METHODS.—Not later than 2 years after the date of enactment of this Act, the Administrator, in consultation with the Secretary of Energy, shall promulgate methods for determining initial and continuing compliance with this section.

(c) PERMIT REQUIREMENT.—Not later than 10 years after the date of enactment of this Act, each generating unit shall have a permit issued under title V of the Clean Air Act (42 U.S.C. 7661 et seq.) that requires compliance with this section.

(d) WAIVER OF COMBUSTION HEAT RATE EFFICIENCY STANDARD.—

(1) APPLICATION.—The owner or operator of a generating unit that commences operation more than 10 years after the date of enactment of this Act may apply to the Administrator for a waiver of the combustion heat rate efficiency standard specified in subsection (a)(2) that is applicable to that type of generating unit.

(2) ISSUANCE.—The Administrator may grant the waiver only if—

(A)(i) the owner or operator of the generating unit demonstrates that the technology to meet the combustion heat rate efficiency standard is not commercially available; or

(ii) the owner or operator of the generating unit demonstrates that, despite best technical efforts and willingness to make the necessary level of financial commitment, the combustion heat rate efficiency standard is not achievable at the generating unit; and

(B) the owner or operator of the generating unit enters into an agreement with the Administrator to offset by a factor of 1.5 to 1, using a method approved by the Administrator, the emission reductions that the generating unit does not achieve because of the failure to achieve the combustion heat rate efficiency standard specified in subsection (a)(2).

(3) EFFECT OF WAIVER.—If the Administrator grants a waiver under paragraph (1), the generating unit shall be required to achieve and maintain, at all operating levels, the combustion heat rate efficiency standard specified in subsection (a)(1).

**SEC. 5. AIR EMISSION STANDARDS FOR FOSSIL FUEL-FIRED GENERATING UNITS.**

(a) ALL FOSSIL FUEL-FIRED GENERATING UNITS.—Not later than 10 years after the date of enactment of this Act, each fossil fuel-fired generating unit, regardless of its date of construction or commencement of operation, shall be subject to, and operating in physical and operational compliance with, the new source review requirements under section 111 of the Clean Air Act (42 U.S.C. 7411).

(b) EMISSION RATES FOR SOURCES REQUIRED TO MAINTAIN 45 PERCENT EFFICIENCY.—Not later than 10 years after the date of enactment of this Act, each fossil fuel-fired generating unit subject to section 4(a)(1) shall be in compliance with the following emission limitations:

(1) MERCURY.—Each coal-fired or fuel oil-fired generating unit shall be required to remove 90 percent of the mercury contained in the fuel, calculated in accordance with subsection (e).

(2) CARBON DIOXIDE.—

(A) NATURAL GAS-FIRED GENERATING UNITS.—Each natural gas-fired generating unit shall be required to achieve an emission rate of not more than 0.9 pounds of carbon dioxide per kilowatt hour of net electric power output.

(B) FUEL OIL-FIRED GENERATING UNITS.—Each fuel oil-fired generating unit shall be required to achieve an emission rate of not more than 1.3 pounds of carbon dioxide per kilowatt hour of net electric power output.

(C) COAL-FIRED GENERATING UNITS.—Each coal-fired generating unit shall be required to achieve an emission rate of not more than 1.55 pounds of carbon dioxide per kilowatt hour of net electric power output.

(3) SULFUR DIOXIDE.—Each fossil fuel-fired generating unit shall be required—

(A) to remove 95 percent of the sulfur dioxide that would otherwise be present in the flue gas; and

(B) to achieve an emission rate of not more than 0.3 pounds of sulfur dioxide per million British thermal units of fuel consumed.

(4) NITROGEN OXIDES.—Each fossil fuel-fired generating unit shall be required—

(A) to remove 90 percent of nitrogen oxides that would otherwise be present in the flue gas; and

(B) to achieve an emission rate of not more than 0.15 pounds of nitrogen oxides per million British thermal units of fuel consumed.

(c) EMISSION RATES FOR SOURCES REQUIRED TO MAINTAIN 50 PERCENT EFFICIENCY.—Each fossil fuel-fired generating unit subject to section 4(a)(2) shall be in compliance with the following emission limitations:

(1) MERCURY.—Each coal-fired or fuel oil-fired generating unit shall be required to remove 90 percent of the mercury contained in the fuel, calculated in accordance with subsection (e).

(2) CARBON DIOXIDE.—

(A) NATURAL GAS-FIRED GENERATING UNITS.—Each natural gas-fired generating unit shall be required to achieve an emission rate of not more than 0.8 pounds of carbon dioxide per kilowatt hour of net electric power output.

(B) FUEL OIL-FIRED GENERATING UNITS.—Each fuel oil-fired generating unit shall be required to achieve an emission rate of not more than 1.2 pounds of carbon dioxide per kilowatt hour of net electric power output.

(C) COAL-FIRED GENERATING UNITS.—Each coal-fired generating unit shall be required to achieve an emission rate of not more than 1.4 pounds of carbon dioxide per kilowatt hour of net electric power output.

(3) SULFUR DIOXIDE.—Each fossil fuel-fired generating unit shall be required—

(A) to remove 95 percent of the sulfur dioxide that would otherwise be present in the flue gas; and

(B) to achieve an emission rate of not more than 0.3 pounds of sulfur dioxide per million British thermal units of fuel consumed.

(4) NITROGEN OXIDES.—Each fossil fuel-fired generating unit shall be required—

(A) to remove 90 percent of nitrogen oxides that would otherwise be present in the flue gas; and

(B) to achieve an emission rate of not more than 0.15 pounds of nitrogen oxides per million British thermal units of fuel consumed.

(d) PERMIT REQUIREMENT.—Not later than 10 years after the date of enactment of this Act, each generating unit shall have a permit issued under title V of the Clean Air Act (42 U.S.C. 7661 et seq.) that requires compliance with this section.

(e) COMPLIANCE DETERMINATION AND MONITORING.—

(1) REGULATIONS.—Not later than 2 years after the date of enactment of this Act, the Administrator, in consultation with the Secretary of Energy, shall promulgate methods for determining initial and continuing compliance with this section.

(2) CALCULATION OF MERCURY EMISSION REDUCTIONS.—Not later than 2 years after the date of enactment of this Act, the Administrator shall promulgate fuel sampling techniques and emission monitoring techniques for use by generating units in calculating mercury emission reductions for the purposes of this section.

(3) REPORTING.—

(A) IN GENERAL.—Not less often than quarterly, the owner or operator of a generating unit shall submit a pollutant-specific emission report for each pollutant covered by this section.

(B) SIGNATURE.—Each report required under subparagraph (A) shall be signed by a responsible official of the generating unit, who shall certify the accuracy of the report.

(C) PUBLIC REPORTING.—The Administrator shall annually make available to the public,

through 1 or more published reports and 1 or more forms of electronic media, facility-specific emission data for each generating unit and pollutant covered by this section.

(D) CONSUMER DISCLOSURE.—Not later than 2 years after the date of enactment of this Act, the Administrator shall promulgate regulations requiring each owner or operator of a generating unit to disclose to residential consumers of electricity generated by the unit, on a regular basis (but not less often than annually) and in a manner convenient to the consumers, data concerning the level of emissions by the generating unit of each pollutant covered by this section and each air pollutant covered by section 111 of the Clean Air Act (42 U.S.C. 7411).

(f) DISPOSAL OF MERCURY CAPTURED OR RECOVERED THROUGH EMISSION CONTROLS.—

(1) CAPTURED OR RECOVERED MERCURY.—Not later than 2 years after the date of enactment of this Act, the Administrator shall promulgate regulations to ensure that mercury that is captured or recovered through the use of an emission control, coal cleaning, or another method is disposed of in a manner that ensures that—

(A) the hazards from mercury are not transferred from 1 environmental medium to another; and

(B) there is no release of mercury into the environment.

(2) MERCURY-CONTAINING SLUDGES AND WASTES.—The regulations promulgated by the Administrator under paragraph (1) shall ensure that mercury-containing sludges and wastes are handled and disposed of in accordance with all applicable Federal and State laws (including regulations).

(g) PUBLIC REPORTING OF FACILITY-SPECIFIC EMISSION DATA.—

(1) IN GENERAL.—The Administrator shall annually make available to the public, through 1 or more published reports and the Internet, facility-specific emission data for each generating unit and for each pollutant covered by this section.

(2) SOURCE OF DATA.—The emission data shall be taken from the emission reports submitted under subsection (e)(3).

**SEC. 6. EXTENSION OF RENEWABLE ENERGY PRODUCTION CREDIT.**

Section 45(c) of the Internal Revenue Code of 1986 (relating to definitions) is amended—

(1) in paragraph (1)—

(A) in subparagraph (B), by striking ''and'';

(B) in subparagraph (C), by striking the period and inserting a comma; and

(C) by adding at the end the following:

''(D) solar power, and

''(E) geothermal power.'';

(2) in paragraph (3)—

(A) in subparagraph (A), by striking ''2002'' and inserting ''2016'';

(B) in subparagraph (B), by striking ''2002'' and inserting ''2016'';

(C) in subparagraph (C), by striking ''2002'' and inserting ''2016''; and

(D) by adding at the end the following:

''(D) SOLAR POWER FACILITY.—In the case of a facility using solar power to produce electricity, the term 'qualified facility' means any facility owned by the taxpayer which is originally placed in service after December 31, 2001, and before January 1, 2016.

''(E) GEOTHERMAL POWER FACILITY.—In the case of a facility using geothermal power to produce electricity, the term 'qualified facility' means any facility owned by the taxpayer which is originally placed in service after December 31, 2001, and before January 1, 2016.''; and

(3) by adding at the end the following:

''(5) SOLAR POWER.—The term 'solar power' means solar energy harnessed through photovoltaic systems, solar boilers which provide process heat, and any other means.

''(6) GEOTHERMAL POWER.—The term 'geothermal power' means thermal energy extracted from the earth for the purposes of producing electricity.''.

**SEC. 7. MEGAWATT HOUR GENERATION FEES.**

(a) IN GENERAL.—Chapter 38 of the Internal Revenue Code of 1986 (relating to miscellaneous excise taxes) is amended by inserting after subchapter D the following:

**''Subchapter E—Megawatt Hour Generation Fees**

''Sec. 4691. Imposition of fees.

**''SEC. 4691. IMPOSITION OF FEES.**

''(a) TAX IMPOSED.—There is hereby imposed on each covered fossil fuel-fired generating unit a tax equal to 30 cents per megawatt hour of electricity produced by the covered fossil fuel-fired generating unit.

''(b) ADJUSTMENT OF RATES.—Not less often than once every 2 years beginning after 2005, the Secretary, in consultation with the Administrator of the Environmental Protection Agency, shall evaluate the rate of the tax imposed by subsection (a) and increase the rate if necessary for any succeeding calendar year to ensure that the Clean Air Trust Fund established by section 9511 has sufficient amounts to fully fund the activities described in section 9511(c).

''(c) PAYMENT OF TAX.—The tax imposed by this section shall be paid quarterly by the owner or operator of each covered fossil fuel-fired generating unit.

''(d) COVERED FOSSIL FUEL-FIRED GENERATING UNIT.—The term 'covered fossil fuel-fired generating unit' means an electric utility generating unit which—

''(1) is powered by fossil fuels;

''(2) has a generating capacity of 5 or more megawatts; and

''(3) because of the date on which the generating unit commenced commercial operation, is not subject to all regulations promulgated under section 111 of the Clean Air Act (42 U.S.C. 7411).''.

(b) CONFORMING AMENDMENT.—The table of subchapters for such chapter 38 is amended by inserting after the item relating to subchapter D the following:

''SUBCHAPTER E. Megawatt hour generation fees.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to electricity produced in calendar years beginning after December 31, 2003.

**SEC. 8. CLEAN AIR TRUST FUND.**

(a) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to trust fund code) is amended by adding at the end the following:

**''SEC. 9511. CLEAN AIR TRUST FUND.**

''(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Clean Air Trust Fund' (hereafter referred to in this section as the 'Trust Fund'), consisting of such amounts as may be appropriated or credited to the Trust Fund as provided in this section or section 9602(b).

''(b) TRANSFERS TO TRUST FUND.—There are hereby appropriated to the Trust Fund amounts equivalent to the taxes received in the Treasury under section 4691.

''(c) EXPENDITURES FROM TRUST FUND.—Amounts in the Trust Fund shall be available, without further Act of appropriation, upon request by the head of the appropriate Federal agency in such amounts as the agency head determines are necessary—

''(1) to provide funding under section 12 of the Clean Power Plant and Modernization Act of 2001, as in effect on the date of enactment of this section;

''(2) to provide funding for the demonstration program under section 13 of such Act, as so in effect;

''(3) to provide assistance under section 15 of such Act, as so in effect;

''(4) to provide assistance under section 16 of such Act, as so in effect; and

''(5) to provide funding under section 17 of such Act, as so in effect.''.

(b) CONFORMING AMENDMENT.—The table of sections for such subchapter A is amended by adding at the end the following:

''Sec. 9511. Clean Air Trust Fund.''.

**SEC. 9. ACCELERATED DEPRECIATION FOR INVESTOR-OWNED GENERATING UNITS.**

(a) IN GENERAL.—Section 168(e)(3) of the Internal Revenue Code of 1986 (relating to classification of certain property) is amended—

(1) in subparagraph (E) (relating to 15-year property), by striking ''and'' at the end of clause (ii), by striking the period at the end of clause (iii) and inserting '', and'', and by adding at the end the following:

''(iv) any 45-percent efficient fossil fuel-fired generating unit.''; and

(2) by adding at the end the following:

''(F) 12-YEAR PROPERTY.—The term '12-year property' includes any 50-percent efficient fossil fuel-fired generating unit.''.

(b) DEFINITIONS.—Section 168(i) of the Internal Revenue Code of 1986 (relating to definitions and special rules) is amended by adding at the end the following:

''(15) FOSSIL FUEL-FIRED GENERATING UNITS.—

''(A) 50-PERCENT EFFICIENT FOSSIL FUEL-FIRED GENERATING UNIT.—The term '50-percent efficient fossil fuel-fired generating unit' means any property used in an investor-owned fossil fuel-fired generating unit pursuant to a plan approved by the Secretary, in consultation with the Administrator of the Environmental Protection Agency, to place into service such a unit which is in compliance with sections 4(a)(2) and 5(c) of the Clean Power Plant and Modernization Act of 2001, as in effect on the date of enactment of this paragraph.

''(B) 45-PERCENT EFFICIENT FOSSIL FUEL-FIRED GENERATING UNIT.—The term '45-percent efficient fossil fuel-fired generating unit' means any property used in an investor-owned fossil fuel-fired generating unit pursuant to a plan so approved to place into service such a unit which is in compliance with sections 4(a)(1) and 5(b) of such Act, as so in effect.''.

(c) CONFORMING AMENDMENT.—The table contained in section 168(c) of the Internal Revenue Code of 1986 (relating to applicable recovery period) is amended by inserting after the item relating to 10-year property the following:

''12-year property ..... 12 years''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to property used after the date of enactment of this Act.

**SEC. 10. GRANTS FOR PUBLICLY OWNED GENERATING UNITS.**

Any capital expenditure made after the date of enactment of this Act to purchase, install, and bring into commercial operation any new publicly owned generating unit that—

(1) is in compliance with sections 4(a)(1) and 5(b) shall, for a 15-year period, be eligible for partial reimbursement through annual grants made by the Secretary of the Treasury, in consultation with the Administrator, in an amount equal to the monetary value of the depreciation deduction that would be realized by reason of section 168(c)(3)(E) of the Internal Revenue Code of 1986 by a similarly-situated investor-owned generating unit over that period; and

(2) is in compliance with sections 4(a)(2) and 5(c) shall, over a 12-year period, be eligible for partial reimbursement through annual grants made by the Secretary of the

Treasury, in consultation with the Administrator, in an amount equal to the monetary value of the depreciation deduction that would be realized by reason of section 168(c)(3)(D) of such Code by a similarly-situated investor-owned generating unit over that period.

**SEC. 11. RECOGNITION OF PERMANENT EMISSION REDUCTIONS IN FUTURE CLIMATE CHANGE IMPLEMENTATION PROGRAMS.**

It is the sense of Congress that—

(1) permanent reductions in emissions of carbon dioxide and nitrogen oxides that are accomplished through the retirement of old generating units and replacement by new generating units that meet the combustion heat rate efficiency and emission standards specified in this Act, or through replacement of old generating units with nonpolluting renewable power generation technologies, should be credited to the utility sector, and to the owner or operator that retires or replaces the old generating unit, in any climate change implementation program enacted by Congress;

(2) the base year for calculating reductions under a program described in paragraph (1) should be the calendar year preceding the calendar year in which this Act is enacted; and

(3) a reasonable portion of any monetary value that may accrue from the crediting described in paragraph (1) should be passed on to utility customers.

**SEC. 12. RENEWABLE AND CLEAN POWER GENERATION TECHNOLOGIES.**

(a) IN GENERAL.—Under the Renewable Energy and Energy Efficiency Technology Act of 1989 (42 U.S.C. 12001 et seq.), the Secretary of Energy shall fund research and development programs and commercial demonstration projects and partnerships to demonstrate the commercial viability and environmental benefits of electric power generation from—

(1) biomass (excluding unseparated municipal solid waste), geothermal, solar, and wind technologies; and

(2) fuel cells.

(b) TYPES OF PROJECTS.—Demonstration projects may include solar power tower plants, solar dishes and engines, co-firing of biomass with coal, biomass modular systems, next-generation wind turbines and wind turbine verification projects, geothermal energy conversion, and fuel cells.

(c) AUTHORIZATION OF APPROPRIATIONS.—In addition to amounts made available under any other law, there is authorized to be appropriated to carry out this section $75,000,000 for each of fiscal years 2003 through 2012.

**SEC. 13. CLEAN COAL, ADVANCED GAS TURBINE, AND COMBINED HEAT AND POWER DEMONSTRATION PROGRAM.**

(a) IN GENERAL.—Under subtitle B of title XXI of the Energy Policy Act of 1992 (42 U.S.C. 13471 et seq.), the Secretary of Energy shall establish a program to fund projects and partnerships designed to demonstrate the efficiency and environmental benefits of electric power generation from—

(1) clean coal technologies, such as pressurized fluidized bed combustion and an integrated gasification combined cycle system;

(2) advanced gas turbine technologies, such as flexible midsized gas turbines and baseload utility scale applications; and

(3) combined heat and power technologies.

(b) SELECTION CRITERIA.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Energy shall promulgate criteria and procedures for selection of demonstration projects and partnerships to be funded under subsection (a).

(2) REQUIRED CRITERIA.—At a minimum, the selection criteria shall include—

(A) the potential of a proposed demonstration project or partnership to reduce or avoid emissions of pollutants covered by section 5 and air pollutants covered by section 111 of the Clean Air Act (42 U.S.C. 7411); and

(B) the potential commercial viability of the proposed demonstration project or partnership.

(c) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—In addition to amounts made available under any other law, there is authorized to be appropriated to carry out this section $75,000,000 for each of fiscal years 2003 through 2012.

(2) DISTRIBUTION.—The Secretary shall make reasonable efforts to ensure that, under the program established under this section, the same amount of funding is provided for demonstration projects and partnerships under each of paragraphs (1), (2), and (3) of subsection (a).

**SEC. 14. EVALUATION OF IMPLEMENTATION OF THIS ACT AND OTHER STATUTES.**

(a) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary of Energy, in consultation with the Chairman of the Federal Energy Regulatory Commission and the Administrator, shall submit to Congress a report on the implementation of this Act.

(b) IDENTIFICATION OF CONFLICTING LAW.—The report shall identify any provision of the Energy Policy Act of 1992 (Public Law 102–486), the Energy Supply and Environmental Coordination Act of 1974 (15 U.S.C. 791 et seq.), the Public Utility Regulatory Policies Act of 1978 (16 U.S.C. 2601 et seq.), or the Powerplant and Industrial Fuel Use Act of 1978 (42 U.S.C. 8301 et seq.), or the amendments made by those Acts, that conflicts with the intent or efficient implementation of this Act.

(c) RECOMMENDATIONS.—The report shall include recommendations from the Secretary of Energy, the Chairman of the Federal Energy Regulatory Commission, and the Administrator for legislative or administrative measures to harmonize and streamline the statutes specified in subsection (b) and the regulations implementing those statutes.

**SEC. 15. ASSISTANCE FOR WORKERS ADVERSELY AFFECTED BY REDUCED CONSUMPTION OF COAL.**

In addition to amounts made available under any other law, there is authorized to be appropriated $75,000,000 for each of fiscal years 2003 through 2015 to provide assistance, under the economic dislocation and worker adjustment assistance program of the Department of Labor authorized by title III of the Job Training Partnership Act (29 U.S.C. 1651 et seq.), to coal industry workers who are terminated from employment as a result of reduced consumption of coal by the electric power generation industry.

**SEC. 16. COMMUNITY ECONOMIC DEVELOPMENT INCENTIVES FOR COMMUNITIES ADVERSELY AFFECTED BY REDUCED CONSUMPTION OF COAL.**

In addition to amounts made available under any other law, there is authorized to be appropriated $75,000,000 for each of fiscal years 2003 through 2012 to provide assistance, under the economic adjustment program of the Department of Commerce authorized by the Public Works and Economic Development Act of 1965 (42 U.S.C. 3121 et seq.), to assist communities adversely affected by reduced consumption of coal by the electric power generation industry.

**SEC. 17. CARBON SEQUESTRATION.**

(a) CARBON SEQUESTRATION STRATEGY.—In addition to amounts made available under any other law, there is authorized to be appropriated to the Environmental Protection Agency and the Department of Energy for each of fiscal years 2003 through 2005 a total of $15,000,000 to conduct research and development activities in basic and applied science in support of development by September 30, 2005, of a carbon sequestration strategy that is designed to offset all growth in carbon dioxide emissions in the United States after 2010.

(b) METHODS FOR BIOLOGICALLY SEQUESTERING CARBON DIOXIDE.—In addition to amounts made available under any other law, there is authorized to be appropriated to the Environmental Protection Agency and the Department of Agriculture for each of fiscal years 2003 through 2012 a total of $30,000,000 to carry out soil restoration, tree planting, wetland protection, and other methods of biologically sequestering carbon dioxide.

(c) LIMITATION.—A project carried out using funds made available under this section shall not be used to offset any emission reduction required under any other provision of this Act.

**SEC. 18. ATMOSPHERIC MONITORING.**

(a) OPERATIONAL SUPPORT.—In addition to amounts made available under any other law, there are authorized to be appropriated for each of fiscal years 2003 through 2012—

(1) for operational support of the National Atmospheric Deposition Program National Trends Network—

(A) $2,000,000 to the United States Geological Survey;

(B) $600,000 to the Environmental Protection Agency;

(C) $600,000 to the National Park Service; and

(D) $400,000 to the Forest Service;

(2) for operational support of the National Atmospheric Deposition Program Mercury Deposition Network—

(A) $400,000 to the Environmental Protection Agency;

(B) $400,000 to the United States Geological Survey;

(C) $100,000 to the National Oceanic and Atmospheric Administration; and

(D) $100,000 to the National Park Service;

(3) for the National Atmospheric Deposition Program Atmospheric Integrated Research Monitoring Network $1,500,000 to the National Oceanic and Atmospheric Administration;

(4) for the Clean Air Status and Trends Network $5,000,000 to the Environmental Protection Agency; and

(5) for the Temporally Integrated Monitoring of Ecosystems and Long-Term Monitoring Program $2,500,000 to the Environmental Protection Agency.

(b) MODERNIZATION.—In addition to amounts made available under any other law, there are authorized to be appropriated—

(1) for equipment and site modernization of the National Atmospheric Deposition Program National Trends Network $6,000,000 to the Environmental Protection Agency;

(2) for equipment and site modernization and network expansion of the National Atmospheric Deposition Program Mercury Deposition Network $2,000,000 to the Environmental Protection Agency;

(3) for equipment and site modernization and network expansion of the National Atmospheric Deposition Program Atmospheric Integrated Research Monitoring Network $1,000,000 to the National Oceanic and Atmospheric Administration; and

(4) for equipment and site modernization and network expansion of the Clean Air Status and Trends Network $4,600,000 to the Environmental Protection Agency.

(c) AVAILABILITY OF AMOUNTS.—Each of the amounts appropriated under subsection (b) shall remain available until expended.

SECTION-BY-SECTION OVERVIEW OF THE CLEAN POWER PLANT AND MODERNIZATION ACT OF 2001

WHAT WILL THE CLEAN POWER PLANT AND MODERNIZATION ACT OF 2001 DO?

The Clean Power Plant and Modernization Act of 2001 lays out an ambitious, achievable, and balanced set of financial incentives and regulatory requirements designed to increase power plant efficiency, reduce emissions, and encourage the use of renewable energy and clean power generation methods. The bill encourages innovation, entrepreneurship, and risk-taking. In the long term, the bill will reduce acid precipitation, decrease mercury contamination, help mitigate climate change, improve visibility, and safeguard human health.

*Section 4. Combustion Heat Rate Efficiency Standards for Fossil Fuel-Fired Generating Units*

Fossil fuel-fired power plants in the United States operate at an average combustion efficiency of 33%. This means that, on average, 67% of the heat generated by burning the fuel is wasted. Without changing fuels, increasing combustion efficiency is the best way to reduce carbon dioxide emissions. Section 4 lays out a phased two-stage process for increasing efficiency. In the first stage, by 10 years after enactment, all units in operation must achieve a combustion heat rate efficiency of not less than 45%. In the second stage, with expected advances in combustion technology, units commencing operation more than 10 years after enactment must achieve a combustion heat rate efficiency of not less than 50%. Carbon dioxide emission reductions on the order of 650 millions tons per year are expected, and the potential exists for even larger reductions.

If, for some unforeseen reason, technological advances do not achieve the 50% efficiency level, Section 4 contains a waiver provision that allows the owners of new units to offset any shortfall in carbon dioxide emission reductions through implementation of carbon sequestration projects.

*Section 5. Air Emission Standards for Fossil Fuel-Fired Generating Units*

Subsection (a) eliminates the ''grandfather'' loophole in the Clean Air Act and requires all units, regardless of when they were constructed or began operation, to comply with existing new source review requirements under Section 111 of the Clean Air Act.

Subsection (b) sets mercury, carbon dioxide, sulfur dioxide, and nitrogen oxide emission standards for units that are subject to the 45% thermal efficiency standard set forth in Section 4. For mercury, 90% of the mercury contained in the fuel must be removed. For carbon dioxide, the emission limits are set by fuel type (i.e., natural gas = 0.9 pounds per kilowatt-hour of output; fuel oil = 1.3 pounds per kilowatt-hour of output; coal = 1.55 pounds per kilowatt-hour of output). 95% of sulfur dioxide emissions and 90% of nitrogen oxide emissions are to be removed, and emissions may not exceed 0.3 pounds of sulfur dioxide and 0.15 pounds of nitrogen oxides per million BTUs of fuel consumed.

Subsection (c) sets emission standards for units that are subject to the 50% thermal efficiency standard set forth in Section 4. Standards for mercury, sulfur dioxide, and nitrogen oxides are the same as those in Subsection (b). Greater combustion efficiency results in lower emissions of carbon dioxide, and the fuel-specific emission limits are lowered accordingly (i.e., natural gas = 0.8 pounds per kilowatt-hour of output; fuel oil = 1.2 pounds per kilowatt-hour of output; coal = 1.4 pounds per kilowatt-hour of output).

*Section 6. Extension of Renewable Energy Production Credit*

Section 45(c) of the Internal Revenue Code of 1986 is amended to include solar power and geothermal power and to extend the renewable energy production credit through 2015. (This credit is currently set to expire in 2001.)

*Section 7. Megawatt-Hour Generation Fees and Section 8. Clean Air Trust Fund*

To offset the impact to the Treasury of the incentives in Sections 9 and 10, the bill establishes the Clean Air Trust Fund. The Trust Fund is similar to the Highway Trust Fund or the Superfund. The revenue for the Trust Fund will be provided by assessing a fee of 30 cents per megawatt-hour of electricity produced by covered electric generating units.

The Trust Fund will also be used to pay for assistance to workers and communities adversely affected by reduced consumption of coal, research and development for renewable power generation technologies (e.g., wind, solar, and biomass), and carbon sequestration projects.

*Section 9. Accelerated Depreciation for Investor-Owned Generating Units*

Under the Internal Revenue Code of 1986, utilities can depreciate their generating equipment over a 20 year period. Section 9 amends Section 168 of the Internal Revenue Code of 1986 to allow for depreciation over a 15 year period for units meeting the 45% efficiency level and the emission standards in Section 5(b). Section 9 also amends Section 168 to allow for depreciation over a 12 year period for units meeting the 50% efficiency level and the emission standards in Section 5(c).

*Section 10. Grants for Publicly Owned Generating Units*

No federal taxes are paid on publicly-owned generating units. To provide publicly-owned utilities with comparable incentives to modernize, Section 10 provides for annual grants in an amount equal to the monetary value of the depreciation deduction that would be realized by a similarly situated investor-owned generating unit under Section 9. Units meeting the 45% efficiency level and the emission standards in Section 5(b) would receive annual grants over a 15 year period, and units meeting the 50% efficiency level and the emission standards in Section 5(c) would receive annual grants over a 12 year period.

*Section 11. Recognition of Permanent Emission Reductions in Future Climate Change Implementation Programs*

This section expresses the sense of Congress that permanent reductions in emissions of carbon dioxide and nitrogen oxides that are accomplished through the retirement of old generating units and replacement by new generating units that meet the efficiency and emission standards in the bill, or through replacement with non-polluting renewable power generation technologies, should be credited to the utility sector and to the owner/operator in any climate change implementation program enacted by Congress.

*Section 12. Renewable and Clean Power Generation Technologies*

This section provides a total of $750 million over 10 years to fund research and development programs and commercial demonstration projects and partnerships to demonstrate the commercial viability and environmental benefits of electric power generation from biomass, geothermal, solar, and wind technologies. Types of projects may include solar power tower plants, solar dishes and engines, co-firing biomass with coal, biomass modular systems, next-generation wind turbines and wind verification projects, and geothermal energy conversion.

*Section 13. Clean Coal, Advanced Gas Turbine, and Combined Heat and Power Demonstration Program*

This section provides a total of $750 million over 10 years to fund research and development programs and commercial demonstration projects and partnerships to demonstrate the commercial viability and environmental benefits of electric power generation from clean coal technologies, advanced gas turbine technologies, and combined heat and power technologies.

*Section 14. Evaluation of Implementation of This Act and Other Statutes*

Not later than 2 years after enactment, DOE, in consultation with EPA and FERC, shall report to Congress on the implementation of the Clean Power Plant and Modernization Act. The report shall identify any provisions of other laws that conflict with the efficient implementation of the Clean Power Plant and Modernization Act. The report shall include recommendations for legislative or administrative measures to harmonize and streamline these other statutes.

*Section 15. Assistance for Workers Adversely Affected by Reduced Consumption of Coal*

Beginning 3 years after enactment, this section provides a total of $975 million over 13 years to provide assistance to coal industry workers who are adversely affected as a result of reduced consumption of coal by the electric power generation industry. The funds will be administered under the economic dislocation and worker adjustment assistance program of the Department of Labor authorized by Title III of the Job Training Partnership Act.

*Section 16. Community Economic Development Incentives for Communities Adversely Affected by Reduced Consumption of Coal*

Beginning 3 years after enactment, this section provides a total of $975 million over 13 years to provide assistance to communities adversely affected as a result of reduced consumption of coal by the electric power generation industry. The funds will be administered under the economic adjustment program of the Department of Commerce authorized by the Public Works and Economic Development Act of 1965.

*Section 17. Carbon Sequestration*

This section authorizes $45 million over 3 years for DOE to conduct research and development in support of a national carbon sequestration strategy. This section also authorizes $300 million over 10 years for EPA and USDA to fund carbon sequestration projects such as soil restoration, tree planting, wetlands protection, and other ways of biologically sequestering carbon.

*Section 18. Atmospheric Monitoring*

This section authorizes $13.6 million over 10 years to support the operation of existing instrument networks that monitor the deposition of sulfates, nitrates, mercury, and other pollutants, as well as the effects of these pollutants of ecosystem health. This section also authorizes a one-time expenditure of $13.6 million for equipment modernization for these instrument networks.

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By Mr. CRAPO:

S. 1132. A bill to amend the Federal Food, Drug, and Cosmetic Act relating to the distribution chain of prescription drugs; to the Committee on Health, Education, Labor, and Pensions.

Mr. CRAPO. Mr. President, I rise today to introduce a bill designed to

prevent a serious disruption in the distribution of prescription drugs across America. Unless changed by this legislation, or modified by the agency itself, a regulation issued by the Food and Drug Administration will drive out of business thousands of small and medium sized drug wholesalers. Tens of thousands of small nursing homes, clinics, doctor's offices, drug stores, and veterinary practices, especially in rural areas, would be forced to find new suppliers of prescription drugs, who would almost certainly charge higher prices. Consumers, especially the sickest and the least able to pay, would be even further hard-pressed to afford the prescription drugs they need to maintain their health.

There is no real health or safety reason behind the FDA's action, which is simply a lack of understanding of how the wholesale distribution of drugs actually works. The agency's regulation would complete the implementation of the Prescription Drug Marketing Act, which was enacted in April 1988. That statute, which was designed to stop the misuse of drug samples, prevent various types of resale fraud, stop the importation of counterfeit drugs, and establish minimum national standards for the storage and handling of drugs by wholesalers, has worked well.

However, the FDA's regulation, which will go into effect on April 1, 2001, created two problems for wholesalers, neither of which were present when the agency issued its initial policy guidance on the statute in 1988. The first problem relates to the sales history of drug products which wholesalers must provide their customers. A wholesaler who does not purchase directly from a manufacturer must provide their customer with a detailed history of all prior sales of that product back to the wholesaler who did purchase the drugs from the manufacturer. This provision was designed to prevent the introduction of counterfeits or other drugs from questionable or unknown sources into the marketplace. The FDA's initial guidance was that resellers who did not purchase drugs directly from a manufacturer had to trace the product back to the wholesaler who did purchase directly from the manufacturer. This wholesaler is known as an authorized distributor.

Not withstanding the fact that this system has produced a drug distribution system of exceptional quality, the FDA has changed its mind as to what the statute required and proposed that a reseller now be required to trace the product history all the way back to the manufacturer. At the same time, however, the agency also concluded that the statute does not require either the manufacturer or the authorized distributor to provide this sales history to the secondary reseller. But without this very detailed sales history, it will be illegal for the secondary wholesaler to resell products. Since it is economically and logistically impractical for manufacturers or authorized distributors to keep track of the huge volume of product in the extreme detail required by the FDA rule, thousands of secondary wholesalers will be forced to cease business.

Fortunately, there is a simple solution. In 1990, the FDA finalized a regulation implementing another part of the PDMA, which requires wholesalers to keep very detailed records of all purchases, sales, or other dispositions of the drugs they obtain. These records, which are very similar to the detailed sales history in the FDA's latest regulation, are also subject to audit by the agency, by state regulators, and must be made available to law enforcement agencies if needed. Thus, there is really no need for a secondary wholesaler to try and assemble the detailed and virtually unobtainable sales history now demanded by the FDA and to pass it on to their customers. Instead, the bill I am introducing today requires only that secondary wholesalers provide a written statement to their customers that the drug products were first purchased from a manufacturer or authorized distributor. Substituting the written statement would prevent a serious disruption in the wholesale drug sector while preserving the original intent of the PDMA, which was to guard the network of licensed and inspected wholesalers from counterfeits or drugs from questionable sources. It would be a simple matter for a secondary wholesaler to determine that a shipment of drugs was first purchased by an authorized wholesaler, and the written statement would be subject to criminal penalties if falsified under existing law. Substituting the written statement for the paper trail requirement would also reduce selling costs, which could be passed on to the consumer.

This bill is a companion to H.R. 68, introduced on January 3, 2001, by Representatives JO ANN EMERSON and MARION BERRY. That bill now has 45 cosponsors who represent an especially diverse geographical and ideological cross section of the House and is supported by nine major trade and professional organizations representing most companies that wholesale or retail prescription drugs in the U.S. I invite my colleagues in the Senate to add their names to this commonsense measure.

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By Mrs. BOXER (for herself, Mrs. CARNAHAN, and Mr. BOND):

S. 1133. A bill to amend title 49, United States Code, to preserve nonstop air service to and from Ronald Reagan Washington National Airport for certain communities in case of airline bankruptcy; to the Committee on Commerce, Science, and Transportation.

Mrs. BOXER. Mr. President, last week the Bush Administration eliminated the only nonstop air service between Los Angeles International Airport, LAX, and National Airport, DCA, in Washington, DC. The elimination of the flight makes Los Angeles the largest U.S. city without nonstop air service to this vital airport in the Nation's capital.

Since the DCA to lax flight began 10 months ago, 45,000 passengers have taken the flight. Not only is it popular, but many small and mid-sized communities throughout the state, including Bakersfield, Fresno, Monterey, and San Luis Obispo, rely on this flight. They have connecting flights into LAX specifically designed so that passengers can take the LAX–DCA nonstop flight. These communities will suffer because of this decision.

This happened because TWA, which operated the flight, went bankrupt. Even though American Airlines purchased the assets of TWA and was willing to continue the flight, the Administration gave the LAX slot at National Airport to another city.

This was an unfortunate decision, and one that was both unnecessary and unjustified. Therefore, today, I am introducing legislation to reinstate the service. It is narrowly crafted to address the unique situation we have here.

My bill only applies in cases where a community loses service to DCA because the airline operating the flight went bankrupt. In those cases, the air carrier that purchases the assets of the bankrupt airlines has a right to continue the nonstop service. In exchange, however, the air carrier must give up one of its several slots that it uses to fly to its hub airport.

In this way, my bill would not create any additional flights to National Airport. Nor would it take away any of the long-distance nonstop flights now in operation, including to the city that just received the slot originally granted to Los Angeles. But, it would allow the very popular nonstop air service between LAX and DCA to continue.

It seems to me that this is a fair compromise to ensure that service between National Airport and Los Angeles continues. I look forward to working with my colleagues to address this problem before the end of the summer.

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By Mr. LIEBERMAN (for himself and Mr. HATCH):

S. 1134. A bill to amend the Internal Revenue Code of 1986 to modify the rules applicable to qualified small business stock; to the Committee on Finance.

Mr. LIEBERMAN. Mr. President, I rise today to introduce legislation to provide an incentive for capital formation for entrepreneurs.

This incentive is tailor-made to form capital for entrepreneurial firms so they can spur economic growth, create high wage jobs, and ensure American competitiveness into the 21st Century. It focuses on equity investments as this is the only form of capital most entrepreneurial firms secure to fund research and development; most such firms are unable to secure debt capital.

Because this incentive applies to founders stock and employee stock options, and not just stock offered to outside investors, it provides a powerful

incentive for the human infrastructure and culture that drives and grows our nation's entrepreneurial firms.

This legislation could not be more timely given the drought we see in equity capital for entrepreneurs. Nationwide we saw 850 Initial Public Offerings of stock, IPOs, in 1996, 610 in 1997, 362 in 1998, 501 in 1999, and 379 in 2000. So far in 2001 we have seen only 50. The total value of these offerings was $47 billion in 1996, $39 billion in 1997, $37 billion in 1998, $53 billion in 1999, and $54 billion in 2000. So far in 2001, it's only $20 billion. Entrepreneurs are starved for capital and this incentive is tailor made to provide an incentive to investors to provide it to them.

The details of our proposal are straight forward. They call for a 100 percent exclusion, a zero capital gains rate, for new, direct, long-term investments in the stock of a small corporation. ''New'' means that the stock must be offered after the effective date of the bill and does not apply to sale of previously acquired equity shares. ''Direct'' means the stock must have been acquired from the firm and not in secondary markets, so it includes founders stock, stock options, venture capital placements, IPOs, and subsequent public stock offerings. ''Long-term'' means the stock must be held for three years. ''Stock'' includes any type of stock, including convertible preferred shares. ''Small corporation'' means a corporation with $300 million or less in capitalization (not valuation, but paid-in capital). The incentive applies to both individual and corporate taxpayers. And the excluded gains are not a preference item for the Alternative Minimum Tax.

I am pleased that Senator HATCH has agreed to serve as the lead cosponsor of the legislation. He and I worked closely together from 1995 through 1997 to restore the capital gains incentive. There were many Members involved with that effort, but Senator HATCH and I were pleased to be the leaders of the legislative coalition that proved to be so effective. Our work now on this venture capital gains legislation is a continuation of that long and successful partnership.

I am pleased that Representatives JENNIFER DUNN and ROBERT MATSUI are introducing the same bill in the other body.

I have long championed this approach to capital gains incentives. Most recently, this proposal was included as Section 4 of S. 798, the Productivity, Opportunity, and Prosperity Act of 2001. The first proposal on this subject was introduced on April 7, 1987 in the 100th Congress by Senator Dale Bumpers as S. 932. I was an early supporter of this proposal and I cosponsored a version of this proposal introduced in 1991 by Senator Bumpers as S.1932. A version of that bill was enacted as part of the 1993 tax bill, Section 1202, but it was laden with technical requirements that limited its effectiveness. In the 104th Congress sent amendments to strengthen Section 1202 to President Clinton in the tax bill vetoed he vetoed in 1996. In the 105th Congress these amendments were included in all of the key capital gains, including S. 2 (Roth), S. 20 (DASCHLE), S. 66 (HATCH-LIEBERMAN), S. 501 (Mack), and S. 745 (Bumpers). These amendments were sent to the conference on that bill but did not emerge from it. A broad-based capital gains incentive, which I supported, was enacted into law and a rollover provision was enacted with regard to Section 1202 stock. In the 106th Congress, amendments to strengthen Section 1202 were introduced in the House by Representatives JENNIFER DUNN and BOB MATSUI, H.R. 2331. Then I introduced the incentive as part of S. 798 and we are today introducing it again as a stand-alone bill.

Today I am pleased to cosponsor S. 818, the capital gains proposal introduced by Senator HATCH and TORRICELLI and others. That proposal calls for a reduction in the current 20 percent capital gains tax rate for a broad class of investments, simplifies the capital gains tax, and provides special benefits to low income taxpayers. This bill and the bill we introduce today are complementary and should both be enacted.

I recognize that the Joint Committee on Taxation, which determines the ''cost'' of all tax proposals, will determine that our proposal today, and S. 818, will lose revenue. I believe this finding to be short-sighted given the dramatic effect that these incentives will have on entrepreneurs and therefore on economic growth, but there is no way to appeal these determinations. There is no revenue remaining available under the budget resolution to tap to finance these proposals. Accordingly, I fully accept the obligation to find a way to pay for these and other tax proposals, an offset, so that we do not adversely affect the deficit.

The reasons for setting a special capital gains rate for venture capital are compelling. Entrepreneurial firms are the ones which can dramatically change our whole health care system, clean up our environment, link us in international telecommunication networks, and increase our capacity to understand our world. The firms are founded by dreamers, adventurers, and risk-takers who embody the best we have to offer in our free-enterprise economy.

Entrepreneurship drives growth and small, emerging companies need capital investment to innovate, create jobs, and create wealth. According to the National Commission on Entrepreneurship, a small subset of entrepreneurial firms that comprise only 5–15 percent of all U.S. businesses created about two-thirds of new jobs between 1993–96. Although venture capital is critical to the transition from a fledgling company to a growth company, only a small share of it is associated with small and new firms. In addition, we are currently experiencing a venture capital slow down that makes it even more difficult for small and new firms to attract capital. According to the National Venture Capital Association, NCVA, investment in the fourth quarter of last year slowed by more than 30 percent from the previous quarter.

The primary goal of the Productivity, Opportunity, and Prosperity Act and this venture capital incentive is to protect, stimulate and expand economic growth. Government's role is not to create jobs but to help create the environment in which the private sector will create jobs. This legislation helps to create the right context for private sector growth by providing incentives for investment in training, technology, and small entrepreneurial firms. These investments are critical to economic growth and the creation of jobs and wealth.

The Productivity, Opportunity, and Prosperity Act of 2001, including this venture capital proposal, is a tax plan with a purpose. And that purpose is, above all else, to stimulate private sector economic growth, to raise the tide that lifts the lot of all Americans. In the spirit of the ''New Economy,'' where the fundamentals of our economy have changed through entrepreneurship and innovation, this package includes business tax incentives that will spur the real drivers of growth: innovation, investment, a skilled workforce, and productivity.

Ten years from now we will be judged by the economic policy decisions we make today. People will ask, did we fully understand the awesome changes taking place in our economy and in our society? Did we give our industry and workers the environment and the tools they need to seize the opportunities that an innovation economy offers? I believe that a true Prosperity Agenda is within our grasp. Never before has America been in a stronger position, economically, socially, or politically, to shape our future. But it will take strong and focused leadership. I am confident that if we in the public sector in Washington work in partnership with the private sector throughout our country, we can truly say of America's future that the best is yet to come. I believe that the Productivity, Opportunity, and Prosperity Act and this venture capital incentive are an important step toward that future.

Mr. President, I ask unanimous consent that the text of the bill and section analysis be printed in the RECORD.

There being no objection the material was ordered to be printed in the RECORD as follows:

S. 1134

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Venture Capital Gains and Growth Act of 2001''.

**SEC. 2. MODIFICATIONS APPLICABLE TO QUALIFIED SMALL BUSINESS STOCK.**

(a) REPEAL OF MINIMUM TAX PREFERENCE.—

(1) IN GENERAL.—Subsection (a) of section 57 of the Internal Revenue Code of 1986 (relating to items of tax preference) is amended by striking paragraph (7).

(2) TECHNICAL AMENDMENT.—Subclause (II) of section 53(d)(1)(B)(ii) of such Code is amended by striking '', (5), and (7)'' and inserting ''and (5)''.

(b) INCREASE IN ROLLOVER PERIOD FOR QUALIFIED SMALL BUSINESS STOCK.—Subsections (a)(1) and (b)(3) of section 1045 of the Internal Revenue Code of 1986 (relating to rollover of gain from qualified small business stock to another qualified small business stock) are each amended by striking ''60-day'' and inserting ''180-day''.

(c) REDUCTION IN HOLDING PERIOD.—

(1) IN GENERAL.—Subsection (a) of section 1202 of the Internal Revenue Code of 1986 (relating to partial exclusion for gains from certain small business stock) is amended by striking ''5 years'' and inserting ''3 years''.

(2) CONFORMING AMENDMENT.—Subsections (g)(2)(A) and (j)(1)(A) of section 1202 of such Code are each amended by striking ''5 years'' and inserting ''3 years''.

(d) REPEAL OF PER-ISSUER LIMITATION.—Section 1202(b) of the Internal Revenue Code of 1986 (relating to per-issuer limitations on taxpayer's eligible gain) is repealed.

(e) QUALIFIED TRADE OR BUSINESS.—Section 1202(e)(3) of the Internal Revenue Code of 1986 (relating to qualified trade or business) is amended by inserting '', and is anticipated to continue to be,'' before ''the reputation'' in subparagraph (A).

(f) OTHER MODIFICATIONS.—

(1) REPEAL OF WORKING CAPITAL LIMITATION.—Section 1202(e)(6) of the Internal Revenue Code of 1986 (relating to working capital) is amended—

(A) in subparagraph (B), by striking ''2 years'' and inserting ''5 years''; and

(B) by striking the last sentence.

(2) EXCEPTION FROM REDEMPTION RULES WHERE BUSINESS PURPOSE.—Section 1202(c)(3) of such Code (relating to certain purchases by corporation of its own stock) is amended by adding at the end the following new subparagraph:

''(D) WAIVER WHERE BUSINESS PURPOSE.—A purchase of stock by the issuing corporation shall be disregarded for purposes of subparagraph (B) if the issuing corporation establishes that there was a business purpose for such purchase and one of the principal purposes of the purchase was not to avoid the limitations of this section.''.

(g) INCREASED EXCLUSION.—

(1) IN GENERAL.—Subsection (a) of section 1202 of the Internal Revenue Code of 1986 (relating to 50-percent exclusion for gain from certain small business stock) is amended by striking ''50 percent'' and inserting ''100 percent''.

(2) CONFORMING AMENDMENTS.—

(A) Subparagraph (A) of section 1(h)(5) of such Code is amended to read as follows:

''(A) collectibles gain, over''.

(B) Section 1(h) of such Code is amended by striking paragraph (8).

(C) Paragraph (9) of section 1(h) of such Code is amended by striking '', gain described in paragraph (7)(A)(i), and section 1202 gain'' and inserting ''and gain described in paragraph (7)(A)(i)''.

(D) Section 1(h) of such Code is amended by redesignating paragraphs (9) (as amended by subparagraph (C)), (10), (11), and (12) as paragraphs (8), (9), (10), and (11), respectively.

(E) The heading for section 1202 of such Code is amended by striking ''**PARTIAL**'' and inserting ''**100-PERCENT**''.

(F) The table of sections for part I of subchapter P of chapter 1 of such Code is amended by striking ''Partial'' in the item relating to section 1202 and inserting ''100-percent''.

(h) EXCLUSION AVAILABLE TO CORPORATIONS.—

(1) IN GENERAL.—Subsection (a) of section 1202 of the Internal Revenue Code of 1986 (relating to partial exclusion for gains from certain small business stock) is amended by striking ''other than a corporation''.

(2) TECHNICAL AMENDMENT.—Subsection (c) of section 1202 of such Code is amended by adding at the end the following new paragraph:

''(4) STOCK HELD AMONG MEMBERS OF CONTROLLED GROUP NOT ELIGIBLE.—Stock of a member of a parent-subsidiary controlled group (as defined in subsection (d)(3)) shall not be treated as qualified small business stock while held by another member of such group.''.

(i) STOCK OF LARGER BUSINESSES ELIGIBLE FOR EXCLUSION.—

(1) IN GENERAL.—Paragraph (1) of section 1202(d) of the Internal Revenue Code of 1986 (defining qualified small business) is amended by striking ''$50,000,000'' each place it appears and inserting ''$300,000,000''.

(2) INFLATION ADJUSTMENT.—Section 1202(d) of such Code (defining qualified small business) is amended by adding at the end the following:

''(4) INFLATION ADJUSTMENT OF ASSET LIMITATION.—In the case of stock issued in any calendar year after 2002, the $300,000,000 amount contained in paragraph (1) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2001' for 'calendar year 1992' in subparagraph (B) thereof.

If any amount as adjusted under the preceding sentence is not a multiple of $10,000, such amount shall be rounded to the nearest multiple of $10,000.''.

(j) EFFECTIVE DATE.—The amendments made by this section shall apply to stock issued after the date of the enactment of this Act.

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*Description of Venture Capital Gains Incentive*

Section 1202 enacted in 1993:

50% capital gains exclusion for new investments—not sale of previously acquired assets—new investments made after effective date, August 1993.

Only if investments made directly in stock—not secondary trading, founders stock, stock options, venture capital, public offerings, common, preferred, convertible preferred.

Only if made in stock of a ''small corporation''—defined as a corporation with $50 million or less in capitalization—ceiling not indexed for inflation.

Only if investment held for five years.

Only if investment made by an individual taxpayer—not by a corporate taxpayer.

50% of the excluded gains not covered by the Alternative Minimum Tax (AMT).

Limit on benefits per taxpayer of ''10 times basis or $10 million, whichever is greater''.

Technical problems—redemption of stock, ''spending speed-up'' provision.

Section 1045 enacted in 1997:

Permits investors in Section 1202 stock to roll over their investments in a new Section 1202 investment without ''realizing'' gains and paying taxes within 60 days.

Nine proposed amendments to Section 1202 and Section 1045:

(1) Sets a zero capital gains rate, compared to the 20 percent rate for other capital gains investments.

Only new investments—same.

Only if direct investments—same.

Only if investment in stock—same.

(2) Apply to corporate taxpayers—now only applies to individual taxpayers.

(3) Define ''small corporation'' as one with $300 million in capitalization and index for inflation—up from $50 million with no indexing.

(4) 100 percent exemption from AMT—now 50 percent exemption.

(5) Increase the time permitted to roll over a Section 1202 investment into another Section 1202 investment to 180 days.

(6) Only if investment held for three years—reduction from five years.

(7) Delete ''10 times or $10 million'' limitation.

(8) Extend coverage of Section 1202 to additional corporations.

(9) Fix technical problems—modify redemption of stock, ''spending speed-up'' provision.

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By Mr. GRAHAM (for himself, Mr. CHAFEE, Mr. CONRAD, Mrs. LINCOLN, Mr. MILLER, Mr. ROCKEFELELR, Mr. BINGAMAN, Mr. KERRY, and Mr. CARPER):

S. 1135. A bill to amend title XVII of the Social Security Act to provide comprehensive reform of the Medicare program, including the provision of coverage of outpatient prescription drugs under such program; to the Committee on Finance.

Mr. GRAHAM. Mr. President, I rise today joined by my colleagues to introduce the Medicare Reform Act of 2001.

Today we are in the midst of a major health-care debate on the Patients' Bill of Rights. This crucial bill should be the beginning, not end, of reform in the health care system. Now we need to take this momentum and turn to Medicare reform.

Reform is not a word to be tossed around lightly. When we bat around the term Medicare reform, this is what we need to be talking about, ideas that go to the very heart of the existing Medicare program and reform it.

The Medicare Reform Act offers such ideas. It keeps what is best about Medicare intact. Under this bill the program will remain, as it has always been, reliable and affordable. But the Medicare Reform Act also does just what it says. It reforms the program to reflect new realities both scientific and economic, that the program's creators could not possibly have planned for in 1965.

One of these realities is that prescription drugs are a crucial part of any modern health care regime. In fact it is unthinkable that prescription drugs would be excluded if Medicare were created today.

The Medicare Reform Act offers a benefit that, like the existing Medicare program, is both affordable and available for all seniors, regardless of income. The benefit also harnesses the power of today's competitive health care marketplace to keep costs down and offer seniors choices.

Perhaps most importantly, the benefit offered by the Medicare Reform Act has no gaps, no caps and no gimmicks.

This is our line-in-the-sand.

Other plans being discussed have major gaps.

Let's look at one: the bill the House Republicans passed last year offers seniors a benefit of a scant $1,050-a year.

Once they hit that cap, coverage stops. It picks up again only if the beneficiary spends $6,000 a year.

Imagine this scenario: An 85-year-old woman pays her monthly prescription drug premium. For the first 6 months of the year, she goes to the drugstore each month to pick up her cholesterol medication and pays $25.

But then she comes to the 7th month, and has hit her benefit cap. Now she has to pay $50 for the same prescription. She's still paying her premium, but she's getting no benefit. Under this benefit, Medicare says ''Sorry. Can't help. Come see me if you have a catastrophe.''

I call plans like this donuts, substance around the edges, giant hole in the middle. I also call them pointless. Who needs insurance you can't be sure of?

No caps, no gaps, no gimmicks. That is set in stone. What is not set is stone is the exact level of the coinsurance or deductible. We're going to be listening to seniors as we move toward a markup, and if we hear they would prefer a lower premium in exchange for higher cost-sharing, we can turn those dials, as long as it's within the parameter of $300 billion.

In structure, the Medicare Reform Act represents a true compromise. It takes the best ideas of all engaged in this issue.

One school of thought has been that the private sector is best equipped to offer an affordable prescription drug benefit.

We agree, up to a point. We do not believe that private insurers should assume all of the risk for this benefit. We do not believe this because private insurers have told us they want no part of this type of system. And we know that we can pass all the laws we want, but we can't make private companies take on Medicare patients.

Rather than foreign the private sector to attempt to do something they do not want to do, we take advantage of the fact that we already have an efficient, workable mechanism in place. That mechanism is the pharmacy benefit manager of PBM. These businesses operate successfully today in every ZIP code of the country. They are in a perfect position to manage the Medicare prescription drug benefit—and to offer seniors a choice.

The Medicare Reform Act would allow multiple PBMs in each geographic region to administer, manage and deliver the prescription drug benefit. They would be allowed to use all of the methods they use currently in the private sector to provide benefits economically, including the use of formularies, preferred pharmacy networks, and generic drug substitution. Additionally, PBMs would be allowed to use mechanisms to encourage beneficiaries to select cost-effective drugs, including the use of disease management and therapeutic interchange programs.

Beneficiareis in every part of the country would have access to coverage provided by PBMs that would not assume full insurance risk for drug costs. In this way, adverse selection and inappropriate incentives would be avoided.

However, to ensure that PBMs pursue and are held accountable for high quality beneficiary services, improved health outcomes, and managing costs, we require PBMs to put a substantial portion of their management fees at risk for their performance. Performance goals would include price discounts and generic substitution rates, timely action with regard to appeals, sustained pharmacy network access and notifications to avoid adverse drug reactions.

Although all PBMs would be required to offer the standard benefit at a minimum, payments received on the basis of their performance could be used to reduce beneficiary cost-sharing or to waive the deductible for generic drugs.

Requiring PBMs to share risk provides a middle ground between proposals that have included no risk being assumed by the private sector, and proposals that have required the assumption of insurance and selection risk for the cost of drugs.

This arrangement would bring us the benefits of private sector competition without the instabilities that would be associated with a full risk-bearing model. It would take advantage of the fact that the private sector has provided an efficient, workable, stable system for the delivery of prescription drugs, and the management of drug costs, and would allow beneficiaries to choose between multiple vendors.

Prescription drugs are not all that is missing from Medicare.

We live in a world of near miracles. We can stop disease in its track. We can keep a health problem from becoming a health crisis. We can make the lives our seniors better. We can make their bodies stronger. We have the technology.

It's time to let our seniors have it as well.

The ''Medicare Reform Act'' would shift the focus of Medicare from simply treating illness to promoting wellness.

Several proven-effective preventive benefits, like cholesterol screening and smoking cessation counseling, would be added to package. These benefits could save lives.

We also provide a new process for changes to the preventive benefit package. As a member of the Finance Committee, I have sat through hours-long discussions on coverage of screening for colorectal cancer. I've heard debated the relative benefits of barium x-rays v. colonscopies in minute details. I'm not qualified to make these decisions. A new ''fast-track'' process would move members of Congress out of the picture of making decisions about the clinical and scientific merits of different benefits, and move the doctors and scientists in.

The Medicare Reform Act is not just about adding benefits. It's also about changing the way we do business.

We've looked to the private sector for lessons on how to run the fee-for-service program. We allow Medicare to use the same competitive tools insurance companies have in place to control costs. This will save the Medicare program money, in contrast to some other competition proposals.

We've looked to the private sector and learned that to serve seniors and providers better, we need to make an investment in the program, and provide additional administrative funds. Our bill gives the agency responsible for these programs the money to truly serve their clients, our seniors.

We've turned again to the medical and scientific experts. We've taken the decision about what Medicare should and shouldn't cover out of the hands of bureaucrats and given it to independent medical, clinical and scientific experts who have the skills to assess new technologies and procedures.

We also need to prepare for the future. The Medicare program is in the best shape it has been in over a quarter century. But, the baby-boomers are going to be joining the program soon.

We need to begin to fortify the program now, so that we are ready for them. Our bill takes modest steps in that direction by indexing the Part B deductible to inflation, and providing the Part B premium subsidy on a sliding scale basis.

While I think we need to spend the lion's share of our efforts on reforming the part of the program with the lion's share of the beneficiaries, we also need to take a close look at the Medicare+Choice program. There are several different proposals on the table to replace the current payment system with one based on competitive bidding, and we face a lot of questions regarding which of the proposals would work best.

In 1997, Senators BREAUX and Mack proposed a Medicare Competitive Pricing Demonstration Project; the Project was included in the Balanced Budget Act. The purpose of the demonstration project was to test a new method of paying plans based on a competitive market approach. It has not yet been implemented.

This demonstration project is exactly what we need to learn how to design and implement a competitive system. It is not sound to undertake a wholesale restructuring of the Medicare+Choice system without knowing what would, and would not, work.

The ''Medicare Reform Act of 2001'' would lay the groundwork for a sound, workable, competitive system by moving forward with the Demonstration project in the state of Florida.

Taken together these disparate pieces represent real reform.

Before the recess, I hope we will have passed legislation to protect basic rights of managed-care patients.

Then we need to pick up that ball and run with it.

The time is now. The money is there. The plan exists. Our seniors are waiting.

By Mr. SARBANES (for himself, Mr. BAUCUS, Mr. BAYH, Mr. CLELAND, Mr. CORZINE, Mr. DODD, Mrs. FEINSTEIN, Mr. REID, Mr. SCHUMER, Ms. SNOWE, Ms. STABENOW, Mr. THOMPSON, and Mr. WYDEN):

S. 1136. A bill to provide for mass transportation in certain Federally owned or managed areas that are open to the general public; to the Committee on Energy and Natural Resources.

Mr. SARBANES. Mr. President, I rise today to introduce legislation to help protect our nation's natural resources and improve the visitor experience in our National Parks and Wildlife Refuges. The Transit in Parks Act, or ''TRIP,'' will establish a new Federal transit grant initiative to support the development of mass transit and alternative transportation services for our national parks, wildlife refuges, Federal recreational areas, and other public lands. I am pleased to be joined by Senators BAUCUS, BAYH, CLELAND, CORZINE, DODD, FEINSTEIN, REID, SCHUMER, SNOWE, STABENOW, THOMPSON, and WYDEN, who are cosponsors of this legislation.

Let me begin with a little history. When the National parks first opened in the second half of the nineteenth century, visitors arrived by stagecoach along dirt roads. Travel through parklands, such as Yosemite or Yellowstone, was long, difficult, and costly. Not many people could afford or endure such a trip. The introduction of the automobile gave every American greater mobility and freedom, which included the freedom to travel and see some of our Nation's great natural wonders. Early in this century, landscape architects from the National Park Service and highway engineers from the U.S. Bureau of Public Roads collaborated to produce many feats of road engineering that opened the National park lands to millions of Americans.

Yet greater mobility and easier access now threaten the very environments that the National Park Service is mandated to protect. The ongoing tension between preservation and access has always been a challenge for our national park system. Today, record numbers of visitors and cars has resulted in increasing damage to our parks. The Grand Canyon alone has almost five million visitors a year. As many as 6,000 vehicles arrive in a single summer day. They compete for 2,400 parking spaces. Between 32,000 and 35,000 tour buses go to the park each year. During the peak summer season, the entrance route becomes a giant parking lot.

In 1975, the total number of visitors to America's national parks was 190 million. By 1999, that number has risen to 287 million annual visitors, almost equal to one visit by every man, woman, and child in this country. This dramatic increase in visitation has created an overwhelming demand on these areas, resulting in severe traffic congestion, visitor restrictions, and in some instances vacationers being shut out of the parks altogether. The environmental damage at the Grand Canyon is visible at many other pars: Yosemite, which has more than four million visitors a year; Yellowstone, which has more than three million visitors a year and experiences such severe traffic congestion that access has to be restricted; Zion; Acadia; Bryce; and many others. We need to solve these problems now or risk permanent harm to our nation's natural, cultural, and historical heritage.

Visitor access to the parks is vital not only to the parks themselves, but to the economic health of their gateway communities. For example, visitors to Yosemite infuse $3 billion a year into the local economy of the surrounding area. At Yellowstone, tourists spend $725 million annually in adjacent communities. Wildlife-related tourism generates an estimated $60 billion a year nationwide. If the parks are forced to close their gates to visitors due to congestion, the economic vitality of the surrounding region would be jeopardized.

The challenge for park management has always been twofold: to conserve and protect the Nation's natural, historical, and cultural resources, while at the same time ensuring visitor access and enjoyment of these sensitive environments. Until now, the principal transportation systems that the Federal Government has developed to provide access into our national parks are roads, primarily for private automobile access. The TRIP legislation recognizes that we need to do more than simply build roads; we must invest in alternative transportation solutions before our national parks are damaged beyond repair.

In developing solutions to the parks' transportation needs, this legislation builds upon the 1997 Memorandum of Understanding between Secretary of Transportation Rodney Slater and Secretary of the Interior Bruce Babbitt, in which the two Departments agreed to work together to address transportation and resource management needs in and around National Parks. The findings in the MOU are especially revealing: Congestion in and approaching many National Parks is causing lengthy traffic delays and backups that substantially detract from the visitor experience. Visitors find that many of the National Parks contain significant noise and air pollution, and traffic congestion similar to that found on the city streets they left behind. In many National Park units, the capacity of parking facilities at interpretive or scenic areas is well below demand. As a result, visitors park along roadsides, damaging park resources and subjecting people to hazardous safety conditions as they walk near busy roads to access visitor use areas. On occasion, National Park units must close their gates during high visitation periods and turn away the public because the existing infrastructure and transportation systems are at, or beyond, the capacity for which they were designed.

In addition, the TRIP legislation is designed to implement the recommendations from a comprehensive study of alternative transportation needs in public lands that I was able to include in the Transportation Equity Act for the 21st Century, TEA–21, as section 3039. The study is nearing completion, and is expected to confirm what those of us who have visited our National parks already know: there is a significant and well-documented need for alternative transportation solutions in the national parks to prevent lasting damage to these incomparable natural treasures.

The Transit in Parks Act will go far toward meeting this need. The bill's objectives are to develop new and expanded mass transit services throughout the national parks and other public lands to conserve and protect fragile natural, cultural, and historical resources and wildlife habitats, to prevent or mitigate adverse impact on those resources and habitats, and to reduce pollution and congestion, while at the same time facilitating appropriate visitor access and improving the visitor experience.

The new Federal transit grant program will provide funding to the Federal land management agencies that manage the 379 various sites within the National Park System, the National Wildlife Refuges, Federal recreational areas, and other public lands, including National Forest System lands, and to their state and local partners. The program will provide capital funds for transit projects, including rail or clean fuel bus projects, joint development activities, pedestrian and bike paths, or park waterway access, within or adjacent to national parks and other public lands. The bill authorizes $65 million for this new program for each of the fiscal years 2002 through 2007. It is anticipated that other resources, both public and private, will be available to augment these amounts.

The bill formalizes the cooperative arrangement in the 1997 MOU between the Secretary of Transportation and the Secretary of the Interior to exchange technical assistance and to develop procedures relating to the planning, selection and funding of transit projects in national park lands. The bill further provides funds for planning, research, and technical assistance that can supplement other financial resources available to the Federal land management agencies. The projects eligible for funding would be developed through the TEA–21 planning process and prioritized for funding by the Secretary of the Interior in consultation and cooperation with the Secretary of Transportation. It is anticipated that the Secretary of the Interior would select projects that are diverse in location and size. While major National

parks such as the Grand Canyon or Yellowstone are clearly appropriate candidates for significant transit projects under this section, there are numerous small urban and rural Federal park lands that can benefit enormously from small projects, such as bike paths or improved connections with an urban or regional public transit system. No single project will receive more than 12 percent of the total amount available in any given year. This ensures a diversity of projects selected for assistance.

In addition, I firmly believe that this program will create new opportunities for the Federal land management agencies to partner with local transit agencies in gateway communities adjacent to the parks, both through the TEA–12 planning process and in developing integrated transportation systems. This will spur new economic development within these communities, as they develop transportation centers for park visitors to connect to transit links into the national parks and other public lands.

The ongoing tension between preservation and access has always been a challenge for the National Park Service. Today, that challenge has new dimensions, with overcrowding, pollution, congestion, and resource degradation increasing at many of our national parks. This legislation—the Transit in Parks Act—will give our Federal land management agencies important new tools to improve both preservation and access. Just as we have found in metropolitan areas, transit is essential to moving large numbers of people in our national parks—quickly, efficiently, at low cost, and without adverse impact. At the same time, transit can enhance the economic development potential of our gateway communities.

As we begin a new millennium, I cannot think of a more worthy endeavor to help our environment and preserve our national parks, wildlife refuges, and Federal recreational areas than by encouraging alternative transportation in these areas. My bill is strongly supported by the American Public Transportation Association, the National Parks Conservation Association, Environmental Defense, Community Transportation Association, Friends of the Earth, National Association of Counties, American Planning Association, Surface Transportation Policy Project, Smart Growth America, Scenic America, National Center for Bicycling and Walking, National Association of Railroad Passengers, Great American Station Foundation, and others.

Mr. President, I urge my colleagues to support this important legislation and to recognize the enormous environmental and economic benefits that transit can bring to our national parks.

I ask unanimous consent that the bill, a section-by-section analysis, and letters of support be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 1136

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Transit in Parks Act'' or the ''TRIP Act''.

**SEC. 2. FEDERAL LAND TRANSIT PROGRAM.**

(a) IN GENERAL.—Chapter 53 of title 49, United States Code, is amended by inserting after section 5315 the following:

**''§ 5316. Federal land transit program**

''(a) FINDINGS AND PURPOSES.—

''(1) FINDINGS.—Congress finds that—

''(A) section 3039 of the Transportation Equity Act for the 21st Century (23 U.S.C. 138 note; Public Law 105–178) required a comprehensive study, to be conducted by the Secretary of Transportation, in coordination with the Secretary of the Interior, of alternative transportation needs in national parks and related public lands in order to—

''(i) identify the transportation strategies that improve the management of national parks and related public lands;

''(ii) identify national parks and related public lands that have existing and potential problems of adverse impact, high congestion, and pollution, or that can otherwise benefit from alternative transportation modes;

''(iii) assess the feasibility of alternative transportation modes; and

''(iv) identify and estimate the costs of those alternative transportation modes;

''(B) many national parks are experiencing increased visitation and congestion and degradation of the natural, historical, and cultural resources;

''(C) there is a growing need for new and expanded mass transportation services throughout national parks to conserve and protect fragile natural, historical, and cultural resources, prevent adverse impact on those resources, and reduce pollution and congestion while facilitating appropriate visitor mobility and accessibility and improving the visitor experience;

''(D) the Department of Transportation can assist the Federal land management agencies through financial support and technical assistance and further the achievement of national goals to—

''(i) enhance the environment;

''(ii) improve mobility;

''(iii) create more livable communities;

''(iv) conserve energy; and

''(v) reduce pollution and congestion in all regions of the country;

''(E) immediate financial and technical assistance by the Department of Transportation, working with Federal land management agencies and State and local governmental authorities to develop efficient and coordinated mass transportation systems within and in the vicinity of eligible areas, is essential to—

''(i) protect and conserve natural, historical, and cultural resources;

''(ii) prevent or mitigate adverse impacts on those resources;

''(iii) relieve congestion;

''(iv) minimize transportation fuel consumption;

''(v) reduce pollution (including noise pollution and visual pollution); and

''(vi) enhance visitor mobility, accessibility, and the visitor experience; and

''(F) it is in the interest of the United States to encourage and promote the development of transportation systems for the betterment of eligible areas to meet the goals described in clauses (i) through (vi) of subparagraph (E).

''(2) PURPOSES.—The purposes of this section are—

''(A) to develop a cooperative relationship between the Secretary of Transportation and the Secretary of the Interior to carry out this section;

''(B) to encourage the planning and establishment of mass transportation systems and nonmotorized transportation systems needed within and in the vicinity of eligible areas, located in both urban and rural areas, that—

''(i) enhance resource protection;

''(ii) prevent or mitigate adverse impacts on those resources;

''(iii) improve visitor mobility, accessibility, and the visitor experience;

''(iv) reduce pollution and congestion;

''(v) conserve energy; and

''(vi) increase coordination with gateway communities;

''(C) to assist Federal land management agencies and State and local governmental authorities in financing areawide mass transportation systems and nonmotorized transportation systems to be operated by public or private mass transportation providers, as determined by local and regional needs, and to encourage public-private partnerships; and

''(D) to assist in research concerning, and development of, improved mass transportation equipment, facilities, techniques, and methods with the cooperation of public and private companies and other entities engaged in the provision of mass transportation service.

''(b) DEFINITIONS.—In this section:

''(1) ELIGIBLE AREA.—

''(A) IN GENERAL.—The term 'eligible area' means any Federally owned or managed park, refuge, or recreational area that is open to the general public.

''(B) INCLUSIONS.—The term 'eligible area' includes—

''(i) a unit of the National Park System;

''(ii) a unit of the National Wildlife Refuge System; and

''(iii) a recreational area managed by the Bureau of Land Management.

''(2) FEDERAL LAND MANAGEMENT AGENCY.—The term 'Federal land management agency' means a Federal agency that manages an eligible area.

''(3) MASS TRANSPORTATION.—

''(A) IN GENERAL.—The term 'mass transportation' means transportation by bus, rail, or any other publicly or privately owned conveyance that provides to the public general or special service on a regular basis.

''(B) INCLUSIONS.—The term 'mass transportation' includes sightseeing service.

''(4) QUALIFIED PARTICIPANT.—The term 'qualified participant' means—

''(A) a Federal land management agency; or

''(B) a State or local governmental authority with jurisdiction over land in the vicinity of an eligible area acting with the consent of the Federal land management agency,

alone or in partnership with a Federal land management agency or other Governmental or nongovernmental participant.

''(5) QUALIFIED PROJECT.—The term 'qualified project' means a planning or capital project in or in the vicinity of an eligible area that—

''(A) is an activity described in section 5302(a)(1), 5303(g), or 5309(a)(1)(A);

''(B) involves—

''(i) the purchase of rolling stock that incorporates clean fuel technology or the replacement of buses of a type in use on the date of enactment of this section with clean fuel vehicles; or

''(ii) the deployment of mass transportation vehicles that introduce innovative technologies or methods;

''(C) relates to the capital costs of coordinating the Federal land management agency mass transportation systems with other mass transportation systems;

''(D) provides a nonmotorized transportation system (including the provision of facilities for pedestrians, bicycles, and nonmotorized watercraft);

''(E) provides waterborne access within or in the vicinity of an eligible area, as appropriate to and consistent with the purposes described in subsection (a)(2); or

''(F) is any other mass transportation project that—

''(i) enhances the environment;

''(ii) prevents or mitigates an adverse impact on a natural resource;

''(iii) improves Federal land management agency resource management;

''(iv) improves visitor mobility and accessibility and the visitor experience;

''(v) reduces congestion and pollution (including noise pollution and visual pollution); and

''(vi) conserves a natural, historical, or cultural resource (excluding rehabilitation or restoration of a nontransportation facility).

''(6) SECRETARY.—The term 'Secretary' means the Secretary of Transportation.

''(c) FEDERAL AGENCY COOPERATIVE ARRANGEMENTS.—The Secretary shall develop cooperative arrangements with the Secretary of the Interior that provide for—

''(1) technical assistance in mass transportation;

''(2) interagency and multidisciplinary teams to develop Federal land management agency mass transportation policy, procedures, and coordination; and

''(3) the development of procedures and criteria relating to the planning, selection, and funding of qualified projects and the implementation and oversight of the program of projects in accordance with this section.

''(d) TYPES OF ASSISTANCE.—

''(1) IN GENERAL.—The Secretary may enter into a contract, grant, cooperative agreement, interagency agreement, intra-agency agreement, or other agreement to carry out a qualified project under this section.

''(2) OTHER USES.—A grant, cooperative agreement, interagency agreement, intra-agency agreement, or other agreement for a qualified project under this section shall be available to finance the leasing of equipment and facilities for use in mass transportation, subject to any regulation that the Secretary may prescribe limiting the grant or agreement to leasing arrangements that are more cost-effective than purchase or construction.

''(e) LIMITATION ON USE OF AVAILABLE AMOUNTS.—

''(1) IN GENERAL.—The Secretary may allocate not more than 5 percent of the amount made available for a fiscal year under section 5338(j) for use by the Secretary in carrying out planning, research, and technical assistance under this section, including the development of technology appropriate for use in a qualified project.

''(2) AMOUNTS FOR PLANNING, RESEARCH, AND TECHNICAL ASSISTANCE.—Amounts made available under this subsection are in addition to amounts otherwise available for planning, research, and technical assistance under this title or any other provision of law.

''(3) AMOUNTS FOR QUALIFIED PROJECTS.—No qualified project shall receive more than 12 percent of the total amount made available under section 5338(j) for any fiscal year.

''(f) PLANNING PROCESS.—In undertaking a qualified project under this section—

''(1) if the qualified participant is a Federal land management agency—

''(A) the Secretary, in cooperation with the Secretary of the Interior, shall develop transportation planning procedures that are consistent with—

''(i) the metropolitan planning provisions under sections 5303 through 5305;

''(ii) the statewide planning provisions under section 135 of title 23; and

''(iii) the public participation requirements under section 5307(c); and

''(B) in the case of a qualified project that is at a unit of the National Park system, the planning process shall be consistent with the general management plans of the unit of the National Park system; and

''(2) if the qualified participant is a State or local governmental authority, or more than 1 State or local governmental authority in more than 1 State, the qualified participant shall—

''(A) comply with sections 5303 through 5305;

''(B) comply with the statewide planning provisions under section 135 of title 23;

''(C) comply with the public participation requirements under section 5307(c); and

''(D) consult with the appropriate Federal land management agency during the planning process.

''(g) COST SHARING.—

''(1) DEPARTMENTAL SHARE.—The Secretary, in cooperation with the Secretary of the Interior, shall establish the share of assistance to be provided under this section to a qualified participant.

''(2) CONSIDERATIONS.—In establishing the departmental share of the net project cost of a qualified project, the Secretary shall consider—

''(A) visitation levels and the revenue derived from user fees in the eligible area in which the qualified project is carried out;

''(B) the extent to which the qualified participant coordinates with a public or private mass transportation authority;

''(C) private investment in the qualified project, including the provision of contract services, joint development activities, and the use of innovative financing mechanisms;

''(D) the clear and direct benefit to the qualified participant; and

''(E) any other matters that the Secretary considers appropriate to carry out this section.

''(3) NONDEPARTMENTAL SHARE.—Notwithstanding any other provision of law, Federal funds appropriated to any Federal land management agency may be counted toward the nondepartmental share of the cost of a qualified project.

''(h) SELECTION OF QUALIFIED PROJECTS.—

''(1) IN GENERAL.—The Secretary of the Interior, after consultation with and in cooperation with the Secretary, shall determine the final selection and funding of an annual program of qualified projects in accordance with this section.

''(2) CONSIDERATIONS.—In determining whether to include a project in the annual program of qualified projects, the Secretary of the Interior shall consider—

''(A) the justification for the qualified project, including the extent to which the qualified project would conserve resources, prevent or mitigate adverse impact, and enhance the environment;

''(B) the location of the qualified project, to ensure that the selected qualified projects—

''(i) are geographically diverse nationwide; and

''(ii) include qualified projects in eligible areas located in both urban areas and rural areas;

''(C) the size of the qualified project, to ensure that there is a balanced distribution;

''(D) the historical and cultural significance of a qualified project;

''(E) safety;

''(F) the extent to which the qualified project would—

''(i) enhance livable communities;

''(ii) reduce pollution (including noise pollution, air pollution, and visual pollution);

''(iii) reduce congestion; and

''(iv) improve the mobility of people in the most efficient manner; and

''(G) any other matters that the Secretary considers appropriate to carry out this section, including—

''(i) visitation levels;

''(ii) the use of innovative financing or joint development strategies; and

''(iii) coordination with gateway communities.

''(i) QUALIFIED PROJECTS CARRIED OUT IN ADVANCE.—

''(1) IN GENERAL.—When a qualified participant carries out any part of a qualified project without assistance under this section in accordance with all applicable procedures and requirements, the Secretary may pay the departmental share of the net project cost of a qualified project if—

''(A) the qualified participant applies for the payment;

''(B) the Secretary approves the payment; and

''(C) before carrying out that part of the qualified project, the Secretary approves the plans and specifications in the same manner as plans and specifications are approved for other projects assisted under this section.

''(2) INTEREST.—

''(A) IN GENERAL.—The cost of carrying out part of a qualified project under paragraph (1) includes the amount of interest earned and payable on bonds issued by a State or local governmental authority, to the extent that proceeds of the bond are expended in carrying out that part.

''(B) LIMITATION.—The rate of interest under this paragraph may not exceed the most favorable rate reasonably available for the qualified project at the time of borrowing.

''(C) CERTIFICATION.—The qualified participant shall certify, in a manner satisfactory to the Secretary, that the qualified participant has exercised reasonable diligence in seeking the most favorable interest rate.

''(j) FULL FUNDING AGREEMENT; PROJECT MANAGEMENT PLAN.—If the amount of assistance anticipated to be required for a qualified project under this section is more than $25,000,000—

''(1) the qualified project shall, to the extent that the Secretary considers appropriate, be carried out through a full funding agreement in accordance with section 5309(g); and

''(2) the qualified participant shall prepare a project management plan in accordance with section 5327(a).

''(k) RELATIONSHIP TO OTHER LAWS.—Qualified participants shall be subject to—

''(1) the requirements of section 5333;

''(2) to the extent that the Secretary determines to be appropriate, requirements consistent with those under subsections (d) and (i) of section 5307; and

''(3) any other terms, conditions, requirements, and provisions that the Secretary determines to be appropriate to carry out this section, including requirements for the distribution of proceeds on disposition of real property and equipment resulting from a qualified project assisted under this section.

''(l) INNOVATIVE FINANCING.—A qualified project assisted under this section shall be eligible for funding through a State Infrastructure Bank or other innovative financing mechanism otherwise available to finance an eligible project under this chapter.

''(m) ASSET MANAGEMENT.—The Secretary may transfer the interest of the Department of Transportation in, and control over, all facilities and equipment acquired under this section to a qualified participant for use and disposition in accordance with any property management regulations that the Secretary determines to be appropriate.

''(n) COORDINATION OF RESEARCH AND DEPLOYMENT OF NEW TECHNOLOGIES.—

''(1) IN GENERAL.—The Secretary, in cooperation with the Secretary of the Interior, may undertake, or make grants or contracts (including agreements with departments, agencies, and instrumentalities of the Federal Government) or other agreements for research, development, and deployment of new technologies in eligible areas that will—

''(A) conserve resources;

''(B) prevent or mitigate adverse environmental impact;

''(C) improve visitor mobility, accessibility, and enjoyment; and

''(D) reduce pollution (including noise pollution and visual pollution).

''(2) ACCESS TO INFORMATION.—The Secretary may request and receive appropriate information from any source.

''(3) FUNDING.—Grants and contracts under paragraph (1) shall be awarded from amounts allocated under subsection (e)(1).

''(o) REPORT.—

''(1) IN GENERAL.—The Secretary, in consultation with the Secretary of the Interior, shall annually submit to the Committee on Transportation and Infrastructure of the House of Representatives and to the Committee on Banking, Housing, and Urban Affairs of the Senate a report on the allocation of amounts to be made available to assist qualified projects under this section .

''(2) ANNUAL AND SUPPLEMENTAL REPORTS.—A report required under paragraph (1) shall be included in the report submitted under section 5309(p).''.

(b) AUTHORIZATIONS.—Section 5338 of title 49, United States Code, is amended by adding at the end the following:

''(j) SECTION 5316.—

''(1) IN GENERAL.—There is authorized to be appropriated to carry out section 5316 $65,000,000 for each of fiscal years 2002 through 2007.

''(2) AVAILABILITY.—Amounts made available under this subsection for any fiscal year shall remain available for obligation until the last day of the third fiscal year commencing after the last day of the fiscal year for which the amounts were initially made available under this subsection.''.

(c) CONFORMING AMENDMENTS.—

(1) TABLE OF SECTIONS.—The table of sections for chapter 53 of title 49, United States Code, is amended by inserting after the item relating to section 5315 the following:

''5316. Federal land transit program.''.

(2) PROJECT MANAGEMENT OVERSIGHT.—Section 5327(c) of title 49, United States Code, is amended in the first sentence—

(A) by striking ''or 5311'' and inserting ''5311, or 5316''; and

(B) by striking ''5311, or'' and inserting ''5311, 5316, or''.

(d) TECHNICAL AMENDMENTS.—Chapter 53 of title 49, United States Code, is amended—

(1) in section 5309—

(A) by redesignating subsection (p) as subsection (q); and

(B) by redesignating the second subsection designated as subsection (o) (as added by section 3009(i) of the Federal Transit Act of 1998 (112 Stat. 356)) as subsection (p);

(2) in section 5328(a)(4), by striking ''5309(o)(1)'' and inserting ''5309(p)(1)''; and

(3) in section 5337, by redesignating the second subsection designated as subsection (e) (as added by section 3028(b) of the Federal Transit Act of 1998 (112 Stat. 367)) as subsection (f).

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TRANSIT IN PARKS ACT—SECTION-BY-SECTION

*Section 1: Short title*

The Transit in Parks (TRIP) Act.

*Section 2: In general*

Amends Federal transit laws by adding new section 5316, ''Federal Land Transit Program.''

*Section 3: Findings and purposes*

The purpose of this Act is to promote the planning and establishment of alternative transportation systems within, and in the vicinity of, the national parks and other public lands to protect and conserve natural, historical, and cultural resources, mitigate adverse impact on those resources, relieve congestion, minimize transportation fuel consumption, reduce pollution, and enhance visitor mobility and accessibility and the visitor experience. The Act responds to the need for alternative transportation systems in the national parks and other public lands identified in the study conducted by the Department of Transportation pursuant to section 3039 of TEA–21, by establishing Federal assistance to finance mass transportation projects within and in the vicinity of the national parks and other public lands, to increase coordination with gateway communities, to encourage public-private partnerships, and to assist in the research and deployment of improved mass transportation equipment and methods.

*Section 4: Definitions*

This section defines eligible projects and eligible participants in the program. A ''qualified participant'' is a Federal land management agency, or a State or local governmental authority acting with the consent of a Federal land management agency. A ''qualified project'' is a planning or capital mass transportation project, including rail projects, clean fuel vehicles, joint development activities, pedestrian and bike paths, waterborne access, or projects that otherwise better protect the eligible areas and increase visitor mobility and accessibility. ''Eligible areas'' are lands managed by the National Park Service, the U.S. Fish and Wildlife Service, and the Bureau of Land Management, as well as any other Federally-owned or -managed park, refuge, or recreational area that is open to the general public. Qualified projects may be located either within eligible areas or in gateway communities in the vicinity of eligible areas.

*Section 5: Federal Agency cooperative arrangements*

This section implements the 1997 Memorandum of Understanding between the Departments of Transportation and the Interior for the exchange of technical assistance in mass transportation, the development of mass transportation policy and coordination, and the establishment of criteria for planning, selection, and funding of projects under this section.

*Section 6: Types of assistance*

This section gives the Secretary of Transportation authority to provide Federal assistance through grants, cooperative agreements, inter- or intra-agency agreements, or other agreements, including leasing under certain conditions, for a qualified project under this section.

*Section 7: Limitation on use of available amounts*

This section specifies that the Secretary may not use more than 5% of the amounts available under this section for planning, research, and technical assistance; these amounts can be supplemented from other sources. In addition, to ensure a broad distribution of funds, no project can receive more than 12% of the total amount available under this section in any given year.

*Section 8: Planning process*

This section requires the Secretaries of Transportation and the Interior to cooperatively develop a planning process consistent with TEA–21 for qualified participants which are Federal land management agencies. If the qualified participant is a State or local governmental authority, the qualified participant shall comply with the TEA–21 planning process and consult with the appropriate Federal land management agency during the planning process.

*Section 9: Department's share of the costs*

This section requires that in determining the Department's share of the project costs, the Secretary of Transportation, in cooperation with the Secretary of the Interior, must consider certain factors, including visitation levels and user fee revenues, coordination in project development with a public or private transit provider, private investment, and whether there is a clear and direct financial benefit to the qualified participant. The intent is to establish criteria for a sliding scale of assistance, with a lower Departmental share for projects that can attract outside investment, and a higher Departmental share for projects that may not have access to such outside resources. In addition, this section specifies that funds from the Federal land management agencies can be counted toward the local share.

*Section 10: Selection of qualified projects*

This section provides that the Secretary of the Interior, in cooperation with the Secretary of Transportation, shall prioritize the qualified projects for funding in an annual program of projects, according to the following criteria: (1) project justification, including the extent to which the project conserves resources, prevents or mitigates adverse impact, and enhances the environment; (2) project location to ensure geographic diversity and both rural and urban projects; (3) project size for a balanced distribution; (4) historical and cultural significance; (5) safety; (6) the extent to which the project would enhance livable communities, reduce pollution and congestion, and improve the mobility of people in the most efficient manner; and (7) any other considerations the Secretary deems appropriate, including visitation levels, the use of innovative financing or joint development strategies, and coordination with gateway communities.

*Section 11: Undertaking projects in advance*

This provision applies current transit law to this section, allowing projects to advance prior to receiving Federal funding, but allowing the advance activities to be counted toward the local share as long as certain conditions are met.

*Section 12: Full funding agreement; project management plan*

This section provides that large projects require a project management plan, and shall be carried out through a full funding agreement to the extent the Secretary considers appropriate.

*Section 13: Relationship to Other Laws*

This provision applies certain transit laws to projects funded under this section, and permits the Secretary to apply any other terms or conditions he or she deems appropriate.

*Section 14: Innovative financing*

This section provides that a project assisted under this Act can also use funding from a State Infrastructure Bank or other innovative financing mechanism that is available to fund other eligible transit projects.

*Section 15: Asset management*

This provision permits the Secretary of Transportation to transfer control over a transit asset acquired with Federal funds under this section to a qualified government

participant in accordance with certain Federal property management rules.

*Section 16. Coordination of research and deployment of new technologies*

This provision allows the Secretary, in cooperation with the Secretary of the Interior, to enter into grants or other agreements for research and deployment of new technologies to meet the special needs of eligible areas under this Act.

*Section 17: Report*

This section requires the Secretary of Transportation to submit a report on projects funded under this section to the House Transportation and Infrastructure Committee and the Senate Banking, Housing, and Urban Affairs Committee, to be included in the Department's annual project report.

*Section 18: Authorization*

$65,000,000 is authorized to be appropriated for the Secretary to carry out this program for each of the fiscal years 2002 through 2007.

*Section 19: Conforming amendments*

Confirming amendments to the transit title, including an amendment to allow 0.5% per year of the funds made available under this section to be used for project management oversight.

*Section 20: Technical amendments*

Technical corrections to the transit title in TEA–21.

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AMERICAN PUBLIC TRANSPORTATION ASSOCIATION,
*Washington, DC, June 6, 2001.*

Hon. PAUL S. SARBANES,
*Chairman, Committee on Banking, Housing, and Urban Affairs,*
*Dirksen Senate Office Building, Washington, DC.*

DEAR SENATOR SARBANES: Thank you for sharing with us a copy of the ''Transit in Parks (TRIP) Act'' which would amend the federal transit law at chapter 53, title 49 U.S.C.

The Act would authorize federal assistance to certain federal agencies and state and local entities to finance mass transportation projects generally for the purpose of addressing transportation congestion and mobility issues at national parks and other eligible areas. In addition, the legislation would encourage enhanced cooperation between the Departments of Transportation and Interior regarding joint efforts of those federal agencies to encourage the use of public transportation at national parks.

I am pleased to support your efforts to improve mobility in our national parks. Public transportation clearly has much to offer citizens who visit these national treasures, where congestion and pollution are significant—and growing—problems. Moreover, this legislation should broaden the base of support for public transportation, a key principle APTA has been advocating for many years. In that regard, we will review your bill with APTA's legislative leadership.

I applaud you for writing the legislation, and look forward to continuing to work with you and your staff. Let us know what we can do to help your initiative!

Sincerely yours,

WILLIAM W. MILLAR,
*President.*

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NATIONAL PARKS CONSERVATION ASSOCIATION,
*Washington, DC, May 23, 2001.*

Hon. PAUL SARBANES,
*Hart Office Building,*
*Washington, DC.*

DEAR SENATOR SARBANES: On behalf of the National Parks Conservation Association (NPCA) and its over 400,000 members, I want to thank you for proposing the Transit in Parks Act that will enhance transit options for access to and within our national parks. NPCA applauds your leadership and foresight in recognizing the critical role that mass transit can play in protecting our parks and improving the visitor experience.

Visitation to America's national parks has skyrocketed during the past two decades, from 190 million visitors in 1975 to approximately 286 million visitors last year. Increased public interest in these special places has placed substantial burdens on the very resources that draw people to the parks. As more and more individuals crowd into our national parks—typically by automobile—fragile habitat, endangered plants and animals, unique cultural treasures, and spectacular natural resources and vistas are being damaged from air and water pollution, noise intrusion, and inappropriate use.

As outlined in your legislation, the establishment of a program within the Department of Transportation dedicated to enhancing transit options in and adjacent to the national parks will have a powerful, positive effect on the future ecological and cultural integrity of the parks. Your initiative will boost the role of alternative transportation solutions for national parks, particularly those most heavily impacted by visitation such as Yellowstone-Grand Teton, Yosemite, Grand Canyon, Acadia, and the Great Smoky Mountains national parks. For instance, development of transportation centers and auto parking lots outside the parks, complemented by the use of buses, vans, or rail systems, and/or bicycle and pedestrian pathways would provide much more efficient means of handling the crush of visitation. The benefit of such systems has already been demonstrated in a number of parks such as Zion and Cape Cod.

Equally important, the legislation will provide an excellent opportunity for the National Park Service (NPS) to enter into public/private partnerships with states, localities, and the private sector, providing a wider range of transportation options than exists today. These partnerships could leverage funds that NPS currently has great difficulty accessing.

NPCA wholeheartedly endorses your bill as a creative new mechanism to fulfill the primary mission of the National Park System: ''to conserve the scenery and the natural and historic objects and the wildlife therein, and to provide for the enjoyment of the same in such manner and by such means as will leave them unimpaired for the enjoyment of future generations.''

We look forward to working with you to move this legislation to enactment

Sincerely,

THOMAS C. KIERNAN,
*President.*

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FRIENDS OF THE EARTH,
*June 27, 2001.*

Hon. PAUL SARBANES,
*Hart Office Building,*
*Washington, DC.*

DEAR SENATOR SARBANES: On behalf of Friends of the Earth, I want to thank you for proposing the Transit in Parks Act. This important bill will enhance transit options for access to and within our national parks. Your leadership in this matter is greatly appreciated.

Americans are visiting our national parks at an unprecedented rate, with visitation growing from 190 million visitors in 1975 to approximately 286 million visitors last year. With increased visitation comes an increased burden on the parks. As more and more individuals take their cars into our national parks, fragile habitat, endangered plants and animals, unique cultural treasures, and spectacular natural resources and vistas are being damaged from air and water pollution, noise intrusion, and inappropriate use.

Your innovative legislation would establish a program within the Department of Transportation dedicated to enhancing transit options in and adjacent to the national parks. This is of vital importance for the future of our national parks. Your initiative will boost the role of alternative transportation solutions for national parks, particularly those most heavily impacted by visitation. For instance, development of transportation centers and auto parking lots outside the parks, complemented by the use of buses, vans, or rail systems, and/or bicycle and pedestrian pathways would provide much more efficient means of handling the crush of visitation. The benefit of such systems has already been demonstrated in a number of parks such as Zion and Cape Cod.

We look forward to working with you to move this legislation to enactment.

Sincerely,

DAVID HIRSCH,
*Transportation Policy Coordinator.*

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ENVIRONMENTAL DEFENSE,
*Washington, DC, May 22, 2001.*

Hon. PAUL SARBANES,
*U.S. Senate,*
*Washington, DC.*

DEAR SENATOR SARBANES: I am writing on behalf of the Environmental Defense Fund and our 300,000 members to express support for your bill, the Transit in Parks Act, which will provide dedicated funding for transit projects in our national parks. Too many of our parks suffer from the consequences of poor transportation systems; traffic congestion, air and water pollution, and disturbance of natural ecosystems.

Increased funding for attractive and effective transit services to and within our national parks is essential to mitigating these growing problems. A good working transit system in a number of our national parks will make the park experience not only more enjoyable for the many families that travel there, it will help improve environmental conditions. Air pollutants that exacerbate respiratory health problems, damage vegetation, and contribute to haze which too often obliterates the views at our parks, will be abated by decreasing the number of cars and congestion levels in the parks. Improved transit related to our parks is key to diversifying transportation choices and access for the benefit of all who might visit our national park system. It is also vital to assuring equal access for all citizens to our parks, including those without cars.

We appreciate your leadership on this issue and your dedication to the health of our national parks and expanded choices in our transportation systems. We look forward to working with you to move your legislation forward.

Sincerely,

MICHAEL REPLOGLE,
*Transportation Director.*

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COMMUNITY TRANSPORTATION ASSOCIATION,
*Washington, DC, June 7, 2001.*

Hon. PAUL SARBANES,
*Committee on Banking, Housing and Urban Affairs,*
*U.S. Senate, Washington, DC.*

DEAR SENATOR SARBANES: The Community Transportation Association continues to support your efforts to provide alternative transportation strategies in our national parks and other public lands. Our association's 3,400 members provide public and community transportation services in many of the smaller communities that border these

national parks, monuments, and recreational areas, and our association has members actively involved in providing transportation services at several national parks.

All of us know the danger that congestion and increases in traffic pose for the future of these sites and locations. Your continued sponsorship of the Transit in Parks Act is an important step in helping ensure that America's natural beauty and historic treasures remain a continuous part of our nation's future. We have members throughout the country whose experiences support the principle that public transit investments in and near national parks and public lands can improve mobility, support the economic vitality of these parks' ''gateway communities,'' and make dramatic improvements in the experiences of park visitors, employees, and community residents alike.

As an illustration of this point, enclosed is an article recently published in our Community Transportation magazine that discusses public transportation as part of the solution to traffic congestion and mobility issues in Acadia, Yosemite and Zion National Parks. These success stories could be replicated in many other communities under your Transit in Parks proposal.

We appreciate your dedicated efforts and initiative in this regard, and look forward to helping you advance this important piece of legislation.

Sincerely,

DALE J. MARSICO,
*Executive Director*.

## AMENDMENTS SUBMITTED AND PROPOSED

SA 831. Mr. BOND (for himself, Mr. ROBERTS, and Mr. HELMS) proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage.

SA 832. Mr. FRIST (for himself, Mr. BREAUX, and Mr. JEFFORDS) submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 833. Mr. WARNER proposed an amendment to the bill S. 1052, supra.

SA 834. Ms. SNOWE (for herself, Mrs. LINCOLN, Mr. DEWINE, Mr. NELSON, of Nebraska, Mr. SPECTER, Mr. MCCAIN, Mr. BAUCUS, Ms. STABENOW, and Mr. CHAFEE) proposed an amendment to the bill S. 1052, supra.

SA 835. Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 836. Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 837. Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 838. Mrs. HUTCHISON submitted an amendment intended to be proposed by her to the bill S. 1052, supra; which was ordered to lie on the table.

SA 839. Mrs. HUTCHISON (for herself and Mrs. CLINTON) submitted an amendment intended to be proposed by her to the bill S. 1052, supra.

SA 840. Mr. ENZI proposed an amendment to the bill S. 1052, supra.

SA 841. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 842. Mr. DEWINE submitted an amendment intended to be proposed by him to the bill S. 1052, supra.

SA 843. Mr. GRAMM (for himself and Mr. MCCAIN) proposed an amendment to the bill S. 1052, supra.

SA 844. Mr. SPECTER proposed an amendment to the bill S. 1052, supra.

SA 845. Mr. GRASSLEY proposed an amendment to the bill S. 1052, supra.

SA 846. Mr. NICKLES (for himself and Mr. ENSIGN) proposed an amendment to the bill S. 1052, supra.

SA 847. Mr. BROWNBACK proposed an amendment to the bill S. 1052, supra.

SA 848. Mr. ENSIGN proposed an amendment to the bill S. 1052, supra.

SA 849. Mr. ENSIGN proposed an amendment to the bill S. 1052, supra.

## TEXT OF AMENDMENTS

**SA 831.** Mr. BOND (for himself, Mr. ROBERTS, and Mr. HELMS) proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

On page 154, between lines 2 and 3, insert the following:

''(11) MINIMUM SHARE OF SETTLEMENT OF AWARD.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), a participant or beneficiary (or the estate of such participant or beneficiary) shall receive not less than 85 percent of any award made as a result of a cause of action brought by the participant or beneficiary (or estate) under this subsection, after subtracting the amount of any attorneys' fees from the total amount of such award.

''(B) EXCEPTION.—This paragraph shall not apply where the amount awarded as a result of a cause of action brought by a participant or beneficiary (or estate) under this subsection is less than $100,000.

''(C) DEFINITIONS.—In this paragraph:

''(i) ATTORNEYS' FEES.—The term 'attorneys' fees' means any compensation for the direct or indirect representation or other legal work performed in connection with a cause of action brought under this subsection. Such term shall not include reimbursements for any expenses incurred in connection with such representation or work.

''(ii) AWARD.—The term 'award' means the sum of—

''(I) any monetary consideration provided to a participant or beneficiary (or the estate of such participant or beneficiary) by a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with a group health plan, or an agent of the plan, issuer, or plan sponsor in connection with a cause of action brought under this subsection, including any monetary consideration provided for in any—

''(aa) final court decision;

''(bb) court order;

''(cc) settlement agreement;

''(dd) arbitration procedure; or

''(ee) alternative dispute resolution procedure (including mediation); plus

''(II) any attorney's fees awarded under subsection (g)(1) with respect to the participant or beneficiary (or estate); less

''(III) any reimbursement for any expenses incurred in connection with direct or indirect representation or other legal work performed in connection with a cause of action under this subsection.

On page 169, between lines 12 and 13, insert the following:

''(11) MINIMUM SHARE OF SETTLEMENT OF AWARD.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), a participant or beneficiary (or the estate of such participant or beneficiary) shall receive not less than 85 percent of any award made as a result of a cause of action brought by the participant or beneficiary (or estate) under this subsection, after subtracting the amount of any attorneys' fees from the total amount of such award.

''(B) EXCEPTION.—This paragraph shall not apply where the amount awarded as a result of a cause of action brought by a participant or beneficiary (or estate) under this subsection is less than $100,000.

''(C) DEFINITIONS.—In this paragraph:

''(i) ATTORNEYS' FEES.—The term 'attorneys' fees' means any compensation for the direct or indirect representation or other legal work performed in connection with a cause of action brought under this subsection. Such term shall not include reimbursements for any expenses incurred in connection with such representation or work.

''(ii) AWARD.—The term 'award' means the sum of—

''(I) any monetary consideration provided to a participant or beneficiary (or the estate of such participant or beneficiary) by a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with a group health plan, or an agent of the plan, issuer, or plan sponsor in connection with a cause of action brought under this subsection, including any monetary consideration provided for in any—

''(aa) final court decision;

''(bb) court order;

''(cc) settlement agreement;

''(dd) arbitration procedure; or

''(ee) alternative dispute resolution procedure (including mediation); less

''(II) any reimbursement for any expenses incurred in connection with direct or indirect representation or other legal work performed in connection with a cause of action under this subsection.''

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**SA 832.** Mr. FRIST (for himself, Mr. BREAUX, and Mr. JEFFORDS) submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

On page 105, line 2, after ''treatment'' insert the following: ''The name of the designated decision-maker (or decision-makers) appointed under section 502(n)(2) of the Employee Retirement Income Security Act of 1974 for purposes of making final determinations under section 103 and approving coverage pursuant to the written determination of an independent medical reviewer under section 104.''.

Beginning on page 139, strike line 21 and all that follows through line 14 on page 171, and insert the following:

**SEC. 302. AVAILABILITY OF COURT REMEDIES.**

(a) IN GENERAL.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended by adding at the end the following:

''(n) CAUSE OF ACTION RELATING TO DENIAL OF A CLAIM FOR HEALTH BENEFITS.—

''(1) IN GENERAL.—

''(A) FAILURE TO COMPLY WITH EXTERNAL MEDICAL REVIEW.—With respect to an action commenced by a participant or beneficiary (or the estate of the participant or beneficiary) in connection with a claim for benefits under a group health plan, if—

''(i) a designated decision-maker described in paragraph (2) fails to exercise ordinary care in approving coverage pursuant to the written determination of an independent medical reviewer under section 104(d)(3)(F) of the Bipartisan Patient Protection Act that reverses a denial of the claim for benefits; and

''(ii) the failure described in clause (i) is the proximate cause of substantial harm (as defined in paragraph (10)(G)) to the participant or beneficiary;

such designated decision-maker shall be liable to the participant or beneficiary (or the estate) for economic and noneconomic damages in connection with such failure and such injury or death (subject to paragraph (4)).

''(B) WRONGFUL DETERMINATION RESULTING IN DELAY IN PROVIDING BENEFITS.—With respect to an action commenced by a participant or beneficiary (or the estate of the participant or beneficiary) in connection with a claim for benefits under a group health plan, if—

''(i) a designated decision-maker described in paragraph (2)—

''(I) fails to exercise ordinary care in making a determination denying the claim for benefits under section 102 of the Bipartisan Patient Protection Act (relating to an initial claim for benefits); or

''(II) fails to exercise ordinary care in making a determination denying the claim for benefits under section 103 of such Act (relating to an internal appeal);

''(ii) the denial described in clause (i) is reversed by an independent medical reviewer under section 104(d) of such Act, or the coverage for the benefit involved is approved after the denial is referred to the independent medical reviewer but prior to the determination of the reviewer under such section; and

''(iii) the delay attributable to the failure described in clause (i) is the proximate cause of substantial harm to, or the wrongful death of, the participant or beneficiary;

such designated decision-maker shall be liable to the participant or beneficiary (or the estate) for economic and noneconomic damages in connection with such failure and such injury or death (subject to paragraph (4)).

''(C) LIMITATION ON LIABILITY BASED ON APPOINTMENT OF DESIGNATED DECISION-MAKER.—If a plan sponsor or named fiduciary appoints a designated decision-maker in accordance with paragraph (2), the plan sponsor or named fiduciary, or any other person or group health plan (or their employees) associated with the plan sponsor or named fiduciary, shall not be liable under this paragraph. The appointment of a designated decision-maker in accordance with paragraph (2) shall not affect the liability of the appointing plan sponsor or named fiduciary for the failure of the plan sponsor or named fiduciary to comply with any other requirement of this title.

''(D) PREVENTION OF DUPLICATION OF ACTION WITH ACTION UNDER STATE LAW.—No action may be brought under this subsection based upon facts and circumstances if a cause of action under State law is brought based upon the same facts and circumstances.

''(2) DESIGNATED DECISION-MAKER.—

''(A) APPOINTMENT.—

''(i) IN GENERAL.—The plan sponsor or named fiduciary of a group health plan shall, in accordance with this paragraph, designate one or more persons to serve as a designated decision-maker with respect to causes of action described in subparagraphs (A) and (B) of paragraph (1), except that—

''(I) with respect to health insurance coverage offered in connection with a group health plan, the health insurance issuer shall be the designated decision-maker unless the plan sponsor and the issuer specifically agree in writing (on a form to be prescribed by the Secretary) to substitute another person as the designated decision-maker; or

''(II) with respect to the designation of a person other than a plan sponsor or health insurance issuer, such person shall satisfy the requirements of subparagraph (D).

''(ii) PLAN DOCUMENTS.—The designated decision-maker shall be specifically designated as such in the written instruments of the plan (under section 402(a)) and be identified as required under section 121(b)(14) of the Bipartisan Patient Protection Act.

''(B) AUTHORITY.—A designated decision-maker appointed under subparagraph (A) shall have the exclusive authority under the group health plan—

''(i) to make determinations with respect to a claim for benefits under section 102 of the Bipartisan Patient Protection Act (relating to an initial claim for benefits);

''(ii) to make final determinations under section 103 of such Act (relating to an internal appeal); or

''(iii) to approve coverage pursuant to the written determination of independent medical reviewers under section 104 of such Act.

''(C) ALLOCATION OF RESPONSIBILITY.—Responsibility may be allocated among different designated decision-makers with respect to—

''(i) for purposes of paragraph (1)(A), the approval of coverage under section 104 of the Bipartisan Patient Protection Act;

''(ii) for purposes of paragraph (1)(B), making determinations on a claim for benefits under section 102 of such Act (relating to an initial claim for benefits); and

''(iii) for purposes of paragraph (1)(B), making final determinations on claims for benefits under section 103 of such Act (relating to internal appeals),

except that not more than one designated decision-maker may be appointed with respect to each level of review under clauses (i), (ii), and (iii). Where such an allocation is made, liability under a cause of action under paragraph (1) shall be assessed against the appropriate designated decision-maker.

''(D) QUALIFICATIONS.—

''(i) CERTIFICATION OF ABILITY.—To be appointed as a designated decision-maker under this paragraph, a person shall provide to the plan sponsor or named fiduciary a certification of such person's ability to meet the requirements of clause (ii) relating to financial obligation for liability under this subsection. Such certification shall be provided upon appointment and not less frequently than annually thereafter, or if the designation is pursuant to a multi-year contract, in conjunction with the renewal of the contract, but in no case less than once every 3 years.

''(ii) OTHER REQUIREMENTS RELATING TO FINANCIAL OBLIGATIONS.—For purposes of clause (i), requirements relating to financial obligation for liability shall include evidence of—

''(I) coverage of the person under insurance policies or other arrangements, secured and maintained by the person, to insure the person against losses arising from professional liability claims, including those arising from being designated as a designated decision-maker under this paragraph; or

''(II) minimum capital and surplus levels that are maintained by the person to cover any losses as a result of liability arising from being designated as a designated decision-maker under this paragraph.

The appropriate amounts of liability insurance and minimum capital and surplus levels for purposes of subclauses (I) and (II) shall be determined by an actuary using sound actuarial principles and accounting practices pursuant to established guidelines of the American Academy of Actuaries and shall be maintained throughout the course of the contract in which such person is designated as a designated decision-maker.

''(E) FLEXIBILITY IN ADMINISTRATION.—A group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, may provide—

''(i) that any person or group of persons may serve in more than one capacity with respect to the plan or coverage (including service as a designated decision-maker, administrator, and named fiduciary); or

''(ii) that a designated decision-maker may employ one or more persons to provide advice with respect to any responsibility of such decision-maker under the plan or coverage.

''(F) FAILURE TO APPOINT.—

''(i) IN GENERAL.—With respect to any cause of action under paragraph (1) relating to a denial of a claim for benefits where a designated decision-maker has not been appointed in accordance with this paragraph, the plan sponsor or named fiduciary responsible for determinations under section 503 shall be deemed to be the designated decision-maker.

''(ii) LIMITATION ON APPOINTMENT.—A treating health care professional who directly delivered the care, treatment, or provided the patient service that is the subject of an action under this subsection may not be designated as a designated decision-maker under this paragraph unless the professional—

''(I) is a person or entity that may be appointed in accordance with subparagraph (A); and

''(II) specifically agrees to accept such appointment in accordance with the requirements under such subparagraph.

''(3) REQUIREMENT OF EXHAUSTION OF INDEPENDENT MEDICAL REVIEW.—

''(A) IN GENERAL.—Paragraph (1) shall apply only if a final determination denying a claim for benefits under section 103 of the Bipartisan Patient Protection Act has been referred for independent medical review under section 104(d) of such Act and a written determination by an independent medical reviewer to reverse such final determination has been issued with respect to such review or where the coverage for the benefit involved is approved after the denial is referred to the independent medical reviewer but prior to the determination of the reviewer under such section.

''(B) EXCEPTION TO EXHAUSTION FOR NEEDED CARE.—A participant or beneficiary may seek relief under subsection 502(a)(1)(B) prior to the exhaustion of administrative remedies under section 103 or 104 of the Bipartisan Patient Protection Act (as required under subparagraph (A)) if it is demonstrated to the court, by a preponderance of the evidence, that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Any determinations that already have been made under section 102, 103, or 104 of such Act in such case, or that are made in such case while an action under this subparagraph is pending, shall be given due consideration by the court in any action under this subsection in such case. Notwithstanding the awarding of relief under subsection 502(a)(1)(B) pursuant to this subparagraph, no relief shall be available under—

''(i) paragraph (1), with respect to a participant or beneficiary, unless the requirements of subparagraph (A) are met; or

''(ii) subsection (q) unless the requirements of such subsection are met.

''(4) LIMITATIONS ON RECOVERY OF DAMAGES.—

''(A) MAXIMUM AWARD OF NONECONOMIC DAMAGES.—The aggregate amount of liability for noneconomic loss in an action under paragraph (1) may not exceed the greater of—

''(i) $750,000; or

''(ii) an amount equal to 3 times the amount awarded for economic loss.

''(B) INCREASE IN AMOUNT.—The amount referred to in subparagraph (A)(i) shall be increased or decreased, for each calendar year that ends after December 31, 2002, by the same percentage as the percentage by which the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, for September of the preceding calendar year has increased or decreased from the such Index for September of 2002.

''(C) SEVERAL LIABILITY.—In the case of any action commenced pursuant to paragraph (1), the designated decision-maker shall be liable only for the amount of noneconomic damages attributable to such designated decision-maker in direct proportion to such decision-maker's share of fault or responsibility for the injury suffered by the participant or beneficiary. In all such cases, the liability of a designated decision-maker for noneconomic damages shall be several and not joint.

''(D) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

''(i) IN GENERAL.—In the case of any action commenced pursuant to paragraph (1), the total amount of damages received by a participant or beneficiary under such action shall be reduced, in accordance with clause (ii), by any other payment that has been, or will be, made to such participant or beneficiary, pursuant to an order or judgment of another court, to compensate such participant or beneficiary for the injury that was the subject of such action.

''(ii) AMOUNT OF REDUCTION.—The amount by which an award of damages to a participant or beneficiary for an injury shall be reduced under clause (i) shall be—

''(I) the total amount of any payments (other than such award) that have been made or that will be made to such participant or beneficiary to pay costs of or compensate such participant or beneficiary for the injury that was the subject of the action; less

''(II) the amount paid by such participant or beneficiary (or by the spouse, parent, or legal guardian of such participant or beneficiary) to secure the payments described in subclause (I).

''(iii) DETERMINATION OF AMOUNTS FROM COLLATERAL SOURCES.—The reduction required under clause (ii) shall be determined by the court in a pretrial proceeding. At the subsequent trial no evidence shall be admitted as to the amount of any charge, payments, or damage for which a participant or beneficiary—

''(I) has received payment from a collateral source or the obligation for which has been assured by a third party; or

''(II) is, or with reasonable certainty, will be eligible to receive from a collateral source which will, with reasonable certainty, be assumed by a third party.

''(E) PROHIBITION OF AWARD OF PUNITIVE DAMAGES.—Notwithstanding any other provision of law, in the case of any action commenced pursuant to paragraph (1), the court may not award any punitive, exemplary, or similar damages against a defendant.

''(5) AFFIRMATIVE DEFENSES.—In the case of any cause of action under paragraph (1), it shall be an affirmative defense that—

''(A) the designated decision-maker of a group health plan, or health insurance issuer that offers health insurance coverage in connection with a group health plan, involved did not receive from the participant or beneficiary (or authorized representative) or the treating health care professional (if any), the information requested by the plan or issuer regarding the medical condition of the participant or beneficiary that was necessary to make a determination on a claim for benefits under section 102 of the Bipartisan Patient Protection Act or a final determination on a claim for benefits under section 103 of such Act;

''(B) the participant or beneficiary (or authorized representative)—

''(i) was in possession of facts that were sufficient to enable the participant or beneficiary (or authorized representative) to know that an expedited review under section 102, 103, or 104 of such Act would have prevented the harm that is the subject of the action; and

''(ii) failed to notify the plan or issuer of the need for such an expedited review; or

''(C) the qualified external review entity or an independent medical reviewer failed to meet the timelines applicable under section 104 of such Act, or a period of time elapsing after coverage has been authorized.

Nothing in this paragraph shall be construed to limit the application of any other affirmative defense that may be applicable to the cause of action involved.

''(6) WAIVER OF INTERNAL REVIEW.—In the case of any cause of action under paragraph (1), the waiver or nonwaiver of internal review under section 103(a)(4) of the Bipartisan Patient Protection Act by the group health plan, or health insurance issuer that offers health insurance coverage in connection with a group health plan, shall not be used in determining liability.

''(7) LIMITATIONS ON ACTIONS.—Paragraph (1) shall not apply in connection with any action that is commenced more than 3 years after the date on which the failure described in paragraph (1) occurred.

''(8) PROTECTION OF THE REGULATION OF QUALITY OF MEDICAL CARE UNDER STATE LAW.—Nothing in this subsection shall be construed to preclude any action under State law against a person or entity for liability or vicarious liability with respect to the delivery of medical care. A claim that is based on or otherwise relates to a group health plan's administration or determination of a claim for benefits (as such term is defined in section 102(e)(2) of the Bipartisan Patient Protection Act and notwithstanding the definition contained in paragraph (10)(B)) shall not be deemed to be the delivery of medical care under any State law for purposes of this section. Any such claim shall be maintained exclusively under section 502.

''(9) CONSTRUCTION.—Nothing in this subsection shall be construed as authorizing a cause of action under paragraph (1) for the failure of a group health plan or health insurance issuer to provide an item or service that is specifically excluded under the plan or coverage.

''(10) DEFINITIONS.—In this subsection:

''(A) AUTHORIZED REPRESENTATIVE.—The term 'authorized representative' has the meaning given such term in section 102(e)(1) of the Bipartisan Patient Protection Act.

''(B) CLAIM FOR BENEFITS.—Except as provided for in paragraph (8), the term 'claim for benefits' shall have the meaning given such term in section 103(e)(2) of the Bipartisan Patient Protection Act, except that such term shall only include claims for which prior authorization is required (as such term is defined in section 151(c)(9) of such Act)).

''(C) GROUP HEALTH PLAN.—The term 'group health plan' shall have the meaning given such term in section 733(a). In applying this paragraph, excepted benefits described in section 733(c) shall not be treated as benefits consisting of medical care.

''(D) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term in section 733(b)(1). In applying this paragraph, excepted benefits described in section 733(c) shall not be treated as benefits consisting of medical care.

''(E) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 733(b)(2).

''(F) ORDINARY CARE.—The term 'ordinary care' means the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent individual acting in a like capacity and familiar with such matters would use in making a determination on a claim for benefits of a similar character.

''(G) SUBSTANTIAL HARM.—The term 'substantial harm' means the loss of life, loss or significant impairment of limb or bodily function, significant mental illness or disease, significant disfigurement, or severe and chronic physical pain.''.

(b) AUTHORITY TO IMPOSE CIVIL PENALTIES FOR FAILURE TO PROVIDE A PLAN BENEFIT NOT ELIGIBLE FOR MEDICAL REVIEW.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by subsection (a), is further amended by adding at the end the following:

''(o) AUTHORITY TO IMPOSE CIVIL PENALTIES FOR FAILURE TO PROVIDE A PLAN BENEFIT NOT ELIGIBLE FOR MEDICAL REVIEW.—In connection with any action maintained under subsection (a)(1)(B), the court, in its discretion, may assess a civil penalty against the designated decision-maker (as designated pursuant to section 502(n)(2)) of a group health plan or a health insurance issuer (that offers health insurance coverage in connection with a group health plan) of not to exceed $100,000 where—

''(1) in its final determination under section 103(d)(2) of the Bipartisan Patient Protection Act, the designated decision-maker fails to provide, or authorize coverage of, a benefit to which a participant or beneficiary is entitled under the terms and conditions of the plan;

''(2) the participant or beneficiary has appealed such determination under section 104 of such Act and such determination is not subject to independent medical review as determined by a qualified external review entity under section 104(c)(3)(A) of such Act;

''(3) the plan has failed to exercise ordinary care in making a final determination under section 103(d)(2) of such Act denying a claim for benefits under the plan; and

''(4) that denial is the proximate cause of substantial harm (as defined in subsection (n)(10)(G)) the participant or beneficiary.''.

(c) LIMITATION ON CERTAIN CLASS ACTION LITIGATION.—

(1) ERISA.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by subsections (a) and (b), is further amended by adding at the end the following:

''(p) LIMITATION ON CLASS ACTION LITIGATION.—

''(1) IN GENERAL.—Any claim or cause of action that is maintained under this section in connection with a group health plan, or health insurance coverage issued in connection with a group health plan, as a class action, derivative action, or as an action on behalf of any group of 2 or more claimants, may be maintained only if the class, the derivative claimant, or the group of claimants is limited to the participants or beneficiaries of a group health plan established by only 1 plan sponsor. No action maintained by such class, such derivative claimant, or such group of claimants may be joined in the same proceeding with any action maintained by another class, derivative claimant, or

group of claimants or consolidated for any purpose with any other proceeding. In this paragraph, the terms 'group health plan' and 'health insurance coverage' have the meanings given such terms in section 733.''.

''(2) EFFECTIVE DATE.—This subsection shall apply to all civil actions that are filed on or after the date of enactment of the Bipartisan Patient Protection Act. This subsection shall apply to civil actions that are pending and have not been finally determined by judgment or settlement prior to such date of enactment.''.

(2) RICO.—Section 1964(c) of title 18, United States Code, is amended—

(1) by inserting ''(1)'' after the subsection designation; and

(2) by adding at the end the following:

''(2)(A) No action may be brought under this subsection, or alleging any violation of section 1962, where the action seeks relief concerning the manner in which any person has marketed, provided information concerning, established, administered, or otherwise operated a group health plan, or health insurance coverage in connection with a group health plan. Any such action shall only be brought under the Employee Retirement Income Security Act of 1974. In this paragraph, the terms 'group health plan' and 'health insurance issuer' shall have the meanings given such terms in section 733 of the Employee Retirement Income Security Act of 1974.

''(B) Subparagraph (A) shall apply to civil actions that are pending and have not been finally determined by judgment or settlement prior to the date of enactment of the Bipartisan Patient Protection Act and all actions commenced on or after such date.''.

(d) CONFORMING AMENDMENT.—Section 502(a)(1)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(a)(1)(A)) is amended by inserting ''or (n)'' after ''subsection (c)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to acts and omissions (from which a cause of action arises) occurring on or after October 1, 2002.

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**SA 833.** Mr. WARNER proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

On page 154, between lines 2 and 3, insert the following:

''(11) LIMITATION ON AWARD OF ATTORNEYS' FEES.—

''(A) IN GENERAL.—Subject to subparagraph (C), with respect to a participant or beneficiary (or the estate of such participant or beneficiary) who brings a cause of action under this subsection and prevails in that action, the amount of attorneys' fees that a court may award to such participant, beneficiary, or estate under subsection (g)(1) (not including the reimbursement of actual out-of-pocket expenses of an attorney as approved by the court in such action) may not exceed the sum of the amounts described in subparagraph (B).

''(B) AMOUNTS DESCRIBED.—For purposes of subparagraph (A), the amounts described in this subparagraph are as follows:

''(i) With respect to a recovery in a cause of action described in subparagraph (A) that does not exceed $100,000, the amount of attorneys' fees awarded may not exceed an amount equal to ⅓ of the amount of the recovery.

''(ii) With respect to a recovery in such a cause of action that exceeds $100,000 but does not exceed $500,000, the amount of the attorneys' fees awarded may not exceed an amount equal to 25 percent of such excess recovery above $100,000.

''(iii) With respect to a recovery in such a cause of action that exceeds $500,000, the amount of the attorneys' fees awarded may not exceed an amount equal to 15 percent of such excess recovery above $500,000.

''(C) EQUITABLE DISCRETION.—A court in its discretion may adjust the amount of an award of attorneys' fees required under subparagraph (A) as equity and the interests of justice may require.

On page 170, between lines 21 and 22, insert the following:

''(9) LIMITATION ON ATTORNEYS' FEES.—

''(A) IN GENERAL.—Notwithstanding any other provision of law, or any arrangement, agreement, or contract regarding attorneys' fees, subject to subparagraph (B), a court shall limit the amount of attorneys' fees that may be incurred for the representation of a participant or beneficiary (or the estate of such participant or beneficiary) who brings a cause of action under paragraph (1) to the amount of attorneys' fees that may be awarded under section 502(n)(11).

''(B) EQUITABLE DISCRETION.—A court in its discretion may adjust the amount of attorneys' fees allowed under subparagraph (A) as equity and the interests of justice may require.''

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**SA 834.** Ms. SNOWE (for herself, Mrs. LINCOLN, Mr. DEWINE, Mr. NELSON of Nebraska, Mr. SPECTER, Mr. MCCAIN, Mr. BAUCUS, Ms. STABENOW, and Mr. CHAFEE) proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

On page 106, between lines 16 and 17, insert the following:

(19) DESIGNATED DECISIONMAKERS.—A description of the participants and beneficiaries with respect to whom each designated decisionmaker under the plan has assumed liability under section 502(o) of the Employee Retirement Income Security Act of 1974 and the name and address of each such decisionmaker.

On page 141, strike lines 16 through 21, and insert the following: ''tions of the plan or coverage, and''.

On page 142, lines 10 and 11, strike ''or the failure described in clause (ii)''.

On page 143, strike lines 12 through 18, and insert the following: ''benefits of like kind to the claims involved.''.

On page 145, strike lines 15 through 20, and insert the following: ''of a denial of a claim for benefits.''.

Beginning on page 145, strike line 22 and all that follows through line 6 on page 146, and insert the following:

''(i) IN GENERAL.—For purposes of subparagraph (B), the term 'direct participation' means, in connection with a decision described in paragraph (1)(A), the actual making of such decision or the actual exercise of control in making such decision.

On page 146, line 14, strike ''clause (i) of''.

On page 146, strike lines 16 through 20, and insert the following: ''or beneficiary, including (but not lim-''.

On page 148, between lines 23 and 24, insert the following:

''(D) APPLICATION TO CERTAIN PLANS.—

''(i) IN GENERAL.—Notwithstanding any other provision of this subsection, no group health plan described in clause (ii) shall be liable under paragraph (1) for the performance of, or the failure to perform, any nonmedically reviewable duty under the plan.

''(ii) DEFINITION.—A group health plan described in this clause is—

''(I) a group health plan that is self-insured and self administered; or

''(II) a group health plan that is maintained by one or more employers or employee organizations described in section 3(16)(B)(iii).

On page 156, between lines 15 and 16, insert the following:

''(17) RELIEF FROM LIABILITY FOR EMPLOYER OR OTHER PLAN SPONSOR BY MEANS OF DESIGNATED DECISIONMAKER.—

''(A) IN GENERAL.—Notwithstanding the direct participation (as defined in paragraph (5)(C)(i)) of an employer or plan sponsor, in any case in which there is deemed to be a designated decisionmaker under subparagraph (B) that meets the requirements of subsection (o)(1) for an employer or other plan sponsor—

''(i) all liability of such employer or plan sponsor (and any employee thereof acting within the scope of employment) under this subsection in connection with any participant or beneficiary shall be transferred to, and assumed by, the designated decisionmaker, and

''(ii) with respect to such liability, the designated decisionmaker shall be substituted for the employer or plan sponsor (or employee) in the action and may not raise any defense that the employer or plan sponsor (or employee) could not raise if such a decisionmaker were not so deemed.

''(B) AUTOMATIC DESIGNATION.—A health insurance issuer shall be deemed to be a designated decisionmaker for purposes of subparagraph (A) with respect to the participants and beneficiaries of an employer or plan sponsor, whether or not the employer or plan sponsor makes such a designation, and shall be deemed to have assumed unconditionally all liability of the employer or plan sponsor under such designation in accordance with subsection (o), unless the employer or plan sponsor affirmatively enters into a contract to prevent the service of the designated decisionmaker.

''(18) PREVIOUSLY PROVIDED SERVICES.—

''(A) IN GENERAL.—Except as provided in this paragraph, a cause of action shall not arise under paragraph (1) where the denial involved relates to an item or service that has already been fully provided to the participant or beneficiary under the plan or coverage and the claim relates solely to the subsequent denial of payment for the provision of such item or service.

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit a cause of action under paragraph (1) where the nonpayment involved results in the participant or beneficiary being unable to receive further items or services that are directly related to the item or service involved in the denial referred to in subparagraph (A) or that are part of a continuing treatment or series of procedures;

''(ii) prohibit a cause of action under paragraph (1) relating to quality of care; or

''(iii) limit liability that otherwise would arise from the provision of the item or services or the performance of a medical procedure.

''(19) EXEMPTION FROM PERSONAL LIABILITY FOR INDIVIDUAL MEMBERS OF BOARDS OF DIRECTORS, JOINT BOARDS OF TRUSTEES, ETC.—Any individual who is—

''(A) a member of a board of directors of an employer or plan sponsor; or

''(B) a member of an association, committee, employee organization, joint board of trustees, or other similar group of representatives of the entities that are the plan sponsor of plan maintained by two or more employers and one or more employee organizations;

shall not be personally liable under this subsection for conduct that is within the scope of employment of the individuals unless the individual acts in a fraudulent manner for personal enrichment.

''(o) REQUIREMENTS FOR DESIGNATED DECISIONMAKERS OF GROUP HEALTH PLANS.—

''(1) IN GENERAL.—For purposes of subsection (n)(17) and section 514(d)(9), a designated decisionmaker meets the requirements of this paragraph with respect to any participant or beneficiary if—

''(A) such designation is in such form as may be prescribed in regulations of the Secretary,

''(B) the designated decisionmaker—

''(i) meets the requirements of paragraph (2),

''(ii) assumes unconditionally all liability of the employer or plan sponsor involved (and any employee thereof acting within the scope of employment) either arising under subsection (n) or arising in a cause of action permitted under section 514(d) in connection with actions (and failures to act) of the employer or plan sponsor (or employee) occurring during the period in which the designation under subsection (n)(17) or section 514(d)(9) is in effect relating to such participant and beneficiary,

''(iii) agrees to be substituted for the employer or plan sponsor (or employee) in the action and not to raise any defense with respect to such liability that the employer or plan sponsor (or employee) may not raise, and

''(iv) where paragraph (2)(B) applies, assumes unconditionally the exclusive authority under the group health plan to make medically reviewable decisions under the plan with respect to such participant or beneficiary, and

''(C) the designated decisionmaker and the participants and beneficiaries for whom the decisionmaker has assumed liability are identified in the written instrument required under section 402(a) and as required under section 121(b)(19) of the Bipartisan Patient Protection Act.

Any liability assumed by a designated decisionmaker pursuant to this subsection shall be in addition to any liability that it may otherwise have under applicable law.

''(2) QUALIFICATIONS FOR DESIGNATED DECISIONMAKERS.—

''(A) IN GENERAL.—Subject to subparagraph (B), an entity is qualified under this paragraph to serve as a designated decisionmaker with respect to a group health plan if the entity has the ability to assume the liability described in paragraph (1) with respect to participants and beneficiaries under such plan, including requirements relating to the financial obligation for timely satisfying the assumed liability, and maintains with the plan sponsor and the Secretary certification of such ability. Such certification shall be provided to the plan sponsor or named fiduciary and to the Secretary upon designation under subsection (n)(17)(B) or section 517(d)(9)(B) and not less frequently than annually thereafter, or if such designation constitutes a multiyear arrangement, in conjunction with the renewal of the arrangement.

''(B) SPECIAL QUALIFICATION IN THE CASE OF CERTAIN REVIEWABLE DECISIONS.—In the case of a group health plan that provides benefits consisting of medical care to a participant or beneficiary only through health insurance coverage offered by a single health insurance issue, such issuer is the only entity that may be qualified under this paragraph to serve as a designated decisionmaker with respect to such participant or beneficiary, and shall serve as the designated decisionmaker unless the employer or other plan sponsor acts affirmatively to prevent such service.

''(3) REQUIREMENTS RELATING TO FINANCIAL OBLIGATIONS.—For purposes of paragraph (2)(A), the requirements relating to the financial obligation of an entity for liability shall include—

''(A) coverage of such entity under an insurance policy or other arrangement, secured and maintained by such entity, to effectively insure such entity against losses arising from professional liability claims, including those arising from its service as a designated decisionmaker under this part; or

''(B) evidence of minimum capital and surplus levels that are maintained by such entity to cover any losses as a result of liability arising from its service as a designated decisionmaker under this part.

The appropriate amounts of liability insurance and minimum capital and surplus levels for purposes of subparagraphs (A) and (B) shall be determined by an actuary using sound actuarial principles and accounting practices pursuant to established guidelines of the American Academy of Actuaries and in accordance with such regulations as the Secretary may prescribe and shall be maintained throughout the term for which the designation is in effect.

''(4) LIMITATION ON APPOINTMENT OF TREATING PHYSICIANS.—A treating physician who directly delivered the care, treatment, or provided the patient service that is the subject of a cause of action by a participant or beneficiary under subsection (n) or section 514(d) may not be designated as a designated decisionmaker under this subsection with respect to such participant or beneficiary.

Beginning on page 161, strike line 14, and all that follows through line 13 on page 162, and insert the following:

''(B) CERTAIN CAUSES OF ACTION PERMITTED.—Notwithstanding subparagraph (A), paragraph (1) applies with respect to any cause of action that is brought by a participant or beneficiary under a group health plan (or the estate of such a participant or beneficiary) to recover damages resulting from personal injury or for wrongful death against any employer or other plan sponsor maintaining the plan (or against an employee of such an employer or sponsor acting within the scope of employment) if such cause of action arises by reason of a medically reviewable decision, to the extent that there was direct participation by the employer or other plan sponsor (or employee) in the decision.

On page 162, lines 19 and 20, strike ''(i) or a failure described in subparagraph (B)(ii)''.

On page 163, line 6, strike ''paragraph (B)(i)'' and insert ''paragraph (B)''.

On page 163, line 8, strike ''or that'' and all that follows through ''ficiary'' on line 11.

On page 170, between lines 21 and 22, insert the following:

''(9) RELIEF FROM LIABILITY FOR EMPLOYER OR OTHER PLAN SPONSOR BY MEANS OF DESIGNATED DECISIONMAKER.—

''(A) IN GENERAL.—Paragraph (1) shall not apply with respect to any cause of action described in paragraph (1)(A) under State law insofar as such cause of action provides for liability of an employer or plan sponsor (or an employee thereof acting within the scope of employment) with respect to a participant or beneficiary, if with respect to the employer or plan sponsor there is deemed to be a designated decisionmaker that meets the requirements of section 502(o)(1) with respect to such participant or beneficiary. Such paragraph (1) shall apply with respect to any cause of action described in paragraph (1)(A) under State law against the designated decisionmaker of such employer or other plan sponsor with respect to the participant or beneficiary.

''(B) AUTOMATIC DESIGNATION.—A health insurance issuer shall be deemed to be a designated decisionmaker for purposes of subparagraph (A) with respect to the participants and beneficiaries of an employer or plan sponsor, whether or not the employer or plan sponsor makes such a designation, and shall be deemed to have assumed unconditionally all liability of the employer or plan sponsor under such designation in accordance with subsection (o), unless the employer or plan sponsor affirmatively enters into a contract to prevent the service of the designated decisionmaker.

''(10) PREVIOUSLY PROVIDED SERVICES.—

''(A) IN GENERAL.—Except as provided in this paragraph, a cause of action shall not arise under paragraph (1) where the denial involved relates to an item or service that has already been fully provided to the participant or beneficiary under the plan or coverage and the claim relates solely to the subsequent denial of payment for the provision of such item or service.

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit a cause of action under paragraph (1) where the nonpayment involved results in the participant or beneficiary being unable to receive further items or services that are directly related to the item or service involved in the denial referred to in subparagraph (A) or that are part of a continuing treatment or series of procedures;

''(ii) prohibit a cause of action under paragraph (1) relating to quality of care; or

''(iii) limit liability that otherwise would arise from the provision of the item or services or the performance of a medical procedure.

''(11) EXEMPTION FROM PERSONAL LIABILITY FOR INDIVIDUAL MEMBERS OF BOARDS OF DIRECTORS, JOINT BOARDS OF TRUSTEES, ETC.—Any individual who is—

''(A) a member of a board of directors of an employer or plan sponsor; or

''(B) a member of an association, committee, employee organization, joint board of trustees, or other similar group of representatives of the entities that are the plan sponsor of plan maintained by two or more employers and one or more employee organizations;

shall not be personally liable under this subsection for conduct that is within the scope of employment of the individuals unless the individual acts in a fraudulent manner for personal enrichment.

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**SA 835.** Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

On page 119, between lines 5 and 6, insert the following:

**SEC. 136. PRESERVATION OF THE HIPPOCRATIC OATH.**

(a) IN GENERAL.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a physician (or group of physicians) shall require that such physician—

(1) provide notice to each participant, beneficiary, or enrollee that the physician treats of whether or not the physician has taken and upholds the Hippocratic Oath; and

(2) in the case of a physician who notifies such participant, beneficiary, or enrollee

that the physician does not uphold any part of the Oath, disclose the part of the Oath to which he or she does not subscribe.

(b) SPECIFIC AREAS OF DISCLOSURE.—A physician making a disclosure under subsection (a)(2) shall, in particular, disclose the following:

(1) That the physician does not hold the patient's health above all other consideration as in accordance with the Hippocratic Oath.

(2) That in violation of the Hippocratic oath the physician engages in physical relationships with his or her patients.

(3) That the physician does not preserve the confidentiality of his or her patients, as is required by the Hippocratic Oath.

(4) That in direct violation of the Hippocratic Oath the physician engages in euthanasia, or suggests council to assist in suicide.

(5) That the physician, in violation of the Hippocratic Oath, performs abortions.

(c) COVERAGE OF OTHER PHYSICIANS.—If a participant, beneficiary or enrollee receives a notice under subsection (a) that a physician has not taken or does not uphold the Hippocratic Oath, the group health plan or health insurance issuer involved shall permit such participant, beneficiary or enrollee to select another physician who has taken or does uphold the Oath. The plan or issuer shall provide coverage for the treatment of services provided by a physician selected under the previous sentence regardless of whether such physician is in the plan or coverage network.

(d) LIMITATION.—Nothing in this section shall be construed to preempt or supersede any State licensure or scope-of-practice law.

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**SA 836.** Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

On page 171, between lines 14 and 15, insert the following:

**SEC. 303. DEDICATION OF PUNITIVE DAMAGES FOR THE PURCHASE OF HEALTH INSURANCE COVERAGE.**

(a) AWARD OF PORTION OF DAMAGES.—

(1) IN GENERAL.—If any penalty is assessed, or non-economic or punitive damages are awarded with respect to a cause of action under section 502(n) or 514(d) of the Employee Retirement Income Security Act of 1974 (as added by section 302), the court shall award the amount described in paragraph (2) to the State health insurance trust fund established under subsection (b) for the State in which the claim was filed to enable the State to provide refundable tax credits to enable individuals in the State to purchase health insurance coverage.

(2) AMOUNT.—The amount awarded to a State under paragraph (1) shall consist of—

(A) any penalty assessed that is not awarded to the aggrieved participant or beneficiary; and

(B) any non-economic or punitive damages awarded in excess of $2,000,000.

(b) STATE REQUIREMENTS.—

(1) STATE HEALTH INSURANCE TRUST FUND.—A State that desires to receive payments under subsection (a) shall establish a State health insurance trust fund.

(2) REFUNDABLE TAX CREDIT.—

(A) IN GENERAL.—The refundable tax credit described in subsection (a)(1) shall—

(i) be available to any resident of a State who—

(I) is without access to adequate health insurance through the resident's employer; or

(II) is from a family with an income that is less that 220 percent of the poverty line, is not eligible for benefits under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), is not eligible for veteran's health benefits, and is younger than 65 years of age; and

(ii) be used to provide a benefit for private insurance that includes, at a minimum, catastrophic coverage.

(B) TIME PERIOD.—

(i) IN GENERAL.—A State shall have in place a refundable tax credit, as described in subsection (a)(1), not later than 2 years after the date of enactment of the Bipartisan Patient Protection Act.

(ii) TRANSFER OF FUNDS.—A State that fails to have a refundable tax credit in place as required by clause (i) shall transfer any funds described in subsection (a)(2) to the National Institutes of Health.

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**SA 837.** Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

At the appropriate place in title I, insert the following:

**SEC. ___. IMPROVED FLEXIBILITY FOR EMPLOYERS IN OBTAINING HEALTH INSURANCE COVERAGE FOR EMPLOYEES.**

(a) FREEDOM FROM EMPLOYER LIABILITY.—In the case of a group health plan, or health insurance coverage provided by a health insurance issuer, that meets the requirements of subsection (b)—

(1) an employer maintaining the plan or entering into an arrangement for the coverage provided by the issuer shall not be liable pursuant to any cause of action relating to the provision of (or failure to provide, or manner of provision of) benefits under any health insurance coverage that may be secured by participants, beneficiaries, or enrollees in connection with the plan, or under the coverage provided by the issuer for participants, beneficiaries, or enrollees; and

(2) there shall be no right of recovery, indemnity, or contribution by a person against such an employer (or an employee of such an employer acting within the scope of employment) for damages assessed against the person pursuant to any such cause of action.

(b) REQUIREMENTS.—A group health plan or health insurance coverage provided by a health insurance issuer meets the requirements of this subsection if—

(1) such plan or coverage provides compensation to employees for personal injuries or sickness, within the meaning of section 106(a) of the Internal Revenue Code of 1986;

(2) under such plan or the arrangement for such coverage, all employer contributions are in the form of payments on behalf of participants, beneficiaries, or enrollees and are placed into a separate trust that forms a part of such plan or the arrangement for such coverage and that meets the additional requirements of subsection (d);

(3) the assets of such trust consist solely of such employer contributions and any income earned from investment of the contributions;

(4) the assets of such trust (other than assets used for payment of necessary and reasonable administrative expenses of the trust) are held in such trust for the sole purpose of, and are available for, payment by participants, beneficiaries, or enrollees of premiums for, or otherwise providing for the cost to participants, beneficiaries, or enrollees of—

(A) health insurance coverage for the participants, beneficiaries, or enrollees that is made available under the plan for acquisition by the participants, beneficiaries, or enrollees and that meets the applicable requirements of law; or

(B) coverage provided by the issuer for participants, beneficiaries, or enrollees that meets the applicable requirements of law;

(5) under such plan or arrangement for such coverage, at least 2 alternative and substantially different forms of health insurance coverage are available for acquisition by each participant, beneficiary, or enrollee with assets of the trust attributable to contributions to the trust on behalf of such participant, beneficiary, or enrollee; and

(6) the participant, beneficiary, or enrollee (and not the employer, plan, or issuer) has a right to the health insurance coverage provided to the participant, beneficiary, or enrollee under the plan or the coverage provided by the issuer.

(c) FIDUCIARY LIABILITY.—In the case of any group health plan or health insurance coverage provided by a health insurance issuer that meets the requirements of subsection (b)—

(1) the trustee of the separate trust referred to in subsection (b)(2) shall be the named fiduciary of the plan or the issuer, with respect to such coverage; and

(2) such trustee shall be treated, for purposes of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) and any other applicable provision of law, as the sole and exclusive fiduciary of the plan or the issuer with respect to assets held in such trust.

(d) SEPARATE TRUST REQUIREMENTS.—

(1) IN GENERAL.—A separate trust referred to in subsection (b)(2) meets the requirements of this subsection if each trustee of the trust—

(A) is not a related party;

(B) does not have a material familial, financial, or professional relationship with such a party; and

(C) does not otherwise have a conflict of interest with such a party (as determined under regulations).

(2) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in paragraph (1) shall be construed to prohibit receipt by a trustee of the separate trust of compensation from the plan or issuer for the conduct of the trustee's duties as trustee, except that any such compensation—

(A) may not exceed a reasonable level; and

(B) may not be contingent on any decision rendered by the trustee in the exercise of the trustee's duties.

(3) RELATED PARTY.—For purposes of this subsection, the term ''related party'' means, in connection with a separate trust forming a part of the plan or the arrangement for such coverage, the plan, the plan sponsor, any health insurance issuer offering the coverage involved, or any fiduciary (except as provided in subsection (c)(2)), officer, director, or employee of such plan, plan sponsor, or issuer.

(e) RULES OF CONSTRUCTION.—

(1) ADDITIONAL EMPLOYEE CONTRIBUTIONS PERMITTED.—The requirements of this section shall not be treated as not met solely because a participant, beneficiary, or enrollee may need to supplement employer contributions provided under the plan or arrangement for coverage for purposes of acquiring health insurance coverage, in order to acquire such coverage.

(2) LIABILITY OF OTHER PARTIES UNAFFECTED.—Nothing in this section shall be construed to affect any cause of action in

connection with the health insurance coverage referred to in subsection (a)(1) against the plan sponsor or health insurance issuer providing such coverage or any other party (other than the employer).

(f) DEFINITIONS.—The definitions contained in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91) shall apply for purposes of this section.

(g) REGULATIONS.—The Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury may issue such regulations as are necessary to carry out the provisions of this section. Such regulations shall be issued consistent with section 104 of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 300gg–92 note).

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**SA 838.** Mrs. HUTCHISON submitted an amendment intended to be proposed by her to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

Beginning on page 98, strike line 2 and all that follows through line 21 on page 109, and insert the following:

**SEC. 121. PATIENT ACCESS TO INFORMATION.**

(a) REQUIREMENT.—

(1) DISCLOSURE.—

(A) IN GENERAL.—A group health plan, and a health insurance issuer that provides coverage in connection with health insurance coverage, shall provide for the disclosure to participants, beneficiaries, and enrollees—

(i) of the information described in subsection (b) at the time of the initial enrollment of the participant, beneficiary, or enrollee under the plan or coverage;

(ii) of such information on an annual basis—

(I) in conjunction with the election period of the plan or coverage if the plan or coverage has such an election period; or

(II) in the case of a plan or coverage that does not have an election period, in conjunction with the beginning of the plan or coverage year;

(iii) of information relating to any material reduction to the benefits or information described in paragraph (1), (2), or (3) of subsection (b), in the form of a notice provided not later than 30 days before the date on which the reduction takes effect; and

(iv) of the additional information described in subsection (c).

(B) PARTICIPANTS, BENEFICIARIES, AND ENROLLEES.—The disclosure required under subparagraph (A) shall be provided—

(i) jointly to each participant, beneficiary, and enrollee who reside at the same address; or

(ii) in the case of a beneficiary or enrollee who does not reside at the same address as the participant or another enrollee, separately to the participant or other enrollees and such beneficiary or enrollee.

(2) PROVISION OF INFORMATION.—Information shall be provided to participants, beneficiaries, and enrollees under this section at the last known address maintained by the plan or issuer with respect to such participants, beneficiaries, or enrollees, to the extent that such information is provided to participants, beneficiaries, or enrollees via the United States Postal Service or other private delivery service.

(b) REQUIRED INFORMATION.—The informational materials to be distributed under this section shall include for each option available under the group health plan or health insurance coverage the following:

(1) DISENROLLMENT.—Information relating to the disenrollment of a participant, beneficiary, or enrollee.

(2) BENEFITS.—A description of the covered benefits, including—

(A) any in- and out-of-network benefits;

(B) specific preventive services covered under the plan or coverage if such services are covered;

(C) any specific exclusions or express limitations of benefits described in section 104(b)(3)(C);

(D) any other benefit limitations, including any annual or lifetime benefit limits and any monetary limits or limits on the number of visits, days, or services, and any specific coverage exclusions; and

(E) any definition of medical necessity used in making coverage determinations by the plan, issuer, or claims administrator.

(3) COST SHARING.—A description of any cost-sharing requirements, including—

(A) any premiums, deductibles, coinsurance, copayment amounts, and liability for balance billing, for which the participant, beneficiary, or enrollee will be responsible under each option available under the plan;

(B) any maximum out-of-pocket expense for which the participant, beneficiary, or enrollee may be liable;

(C) any cost-sharing requirements for out-of-network benefits or services received from nonparticipating providers; and

(D) any additional cost-sharing or charges for benefits and services that are furnished without meeting applicable plan or coverage requirements, such as prior authorization or precertification.

(4) COMPENSATION METHODS.—A summary description by category of the applicable methods (such as capitation, fee-for-service, salary, bundled payments, per diem, or a combination thereof) used for compensating prospective or treating health care professionals (including primary care providers and specialists) and facilities in connection with the provision of health care under the plan or coverage.

(c) ADDITIONAL INFORMATION.—The informational materials to be provided upon the request of a participant, beneficiary, or enrollee, as provided for under subsection (d), and through other, easily accessible means, including electronically via the Internet, shall include for each option available under a group health plan or health insurance coverage the following:

(1) SERVICE AREA.—A description of the plan or issuer's service area, including the provision of any out-of-area coverage.

(2) PARTICIPATING PROVIDERS.—A directory of participating providers (to the extent a plan or issuer provides coverage through a network of providers) that includes, at a minimum, the name, address, and telephone number of each participating provider, and information about how to inquire whether a participating provider is currently accepting new patients, and the State licensure status of the providers and participating health care facilities, and, if available, the education, training, specialty qualifications or certifications of such professionals.

(3) CHOICE OF PRIMARY CARE PROVIDER.—A description of any requirements and procedures to be used by participants, beneficiaries, and enrollees in selecting, accessing, or changing their primary care provider, including providers both within and outside of the network (if the plan or issuer permits out-of-network services), and the right to select a pediatrician as a primary care provider under section 116 for a participant, beneficiary, or enrollee who is a child if such section applies.

(4) PREAUTHORIZATION REQUIREMENTS.—A description of the requirements and procedures to be used to obtain preauthorization for health services, if such preauthorization is required.

(5) EXPERIMENTAL AND INVESTIGATIONAL TREATMENTS.—A description of the process for determining whether a particular item, service, or treatment is considered experimental or investigational, and the circumstances under which such treatments are covered by the plan or issuer.

(6) SPECIALTY CARE.—A description of the requirements and procedures to be used by participants, beneficiaries, and enrollees in accessing specialty care and obtaining referrals to participating and nonparticipating specialists, including any limitations on choice of health care professionals referred to in section 112(b)(2) and the right to timely access to specialists care under section 114 if such section applies.

(7) CLINICAL TRIALS.—A description of the circumstances and conditions under which participation in clinical trials is covered under the terms and conditions of the plan or coverage, and the right to obtain coverage for approved clinical trials under section 119 if such section applies.

(8) PRESCRIPTION DRUGS.—To the extent the plan or issuer provides coverage for prescription drugs, a statement of whether such coverage is limited to drugs included in a formulary, a description of any provisions and cost-sharing required for obtaining on- and off-formulary medications, and a description of the rights of participants, beneficiaries, and enrollees in obtaining access to access to prescription drugs under section 118 if such section applies.

(9) EMERGENCY SERVICES.—A summary of the rules and procedures for accessing emergency services, including the right of a participant, beneficiary, or enrollee to obtain emergency services under the prudent layperson standard under section 113, if such section applies, and any educational information that the plan or issuer may provide regarding the appropriate use of emergency services.

(10) CLAIMS AND APPEALS.—A description of the plan or issuer's rules and procedures pertaining to claims and appeals, a description of the rights (including deadlines for exercising rights) of participants, beneficiaries, and enrollees under subtitle A in obtaining covered benefits, filing a claim for benefits, and appealing coverage decisions internally and externally (including telephone numbers and mailing addresses of the appropriate authority), and a description of any additional legal rights and remedies available under section 502 of the Employee Retirement Income Security Act of 1974 and applicable State law.

(11) ADVANCE DIRECTIVES AND ORGAN DONATION.—A description of procedures for advance directives and organ donation decisions if the plan or issuer maintains such procedures.

(12) INFORMATION ON PLANS AND ISSUERS.—The name, mailing address, and telephone number or numbers of the plan administrator and the issuer to be used by participants, beneficiaries, and enrollees seeking information about plan or coverage benefits and services, payment of a claim, or authorization for services and treatment. Notice of whether the benefits under the plan or coverage are provided under a contract or policy of insurance issued by an issuer, or whether benefits are provided directly by the plan sponsor who bears the insurance risk.

(13) TRANSLATION SERVICES.—A summary description of any translation or interpretation services (including the availability of printed information in languages other than English, audio tapes, or information in Braille) that are available for non-English speakers and participants, beneficiaries, and enrollees with communication disabilities

and a description of how to access these items or services.

(14) ACCREDITATION INFORMATION.—Any information that is made public by accrediting organizations in the process of accreditation if the plan or issuer is accredited, or any additional quality indicators (such as the results of enrollee satisfaction surveys) that the plan or issuer makes public or makes available to participants, beneficiaries, and enrollees.

(15) NOTICE OF REQUIREMENTS.—A description of any rights of participants, beneficiaries, and enrollees that are established by the Bipartisan Patient Protection Act (excluding those described in paragraphs (1) through (14)) if such sections apply. The description required under this paragraph may be combined with the notices of the type described in sections 711(d), 713(b), or 606(a)(1) of the Employee Retirement Income Security Act of 1974 and with any other notice provision that the appropriate Secretary determines may be combined, so long as such combination does not result in any reduction in the information that would otherwise be provided to the recipient.

(16) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, timeframes, and appeals rights) under any utilization review program under sections 101 and 102, including any drug formulary program under section 118.

(17) EXTERNAL APPEALS INFORMATION.—Aggregate information on the number and outcomes of external medical reviews, relative to the sample size (such as the number of covered lives) under the plan or under the coverage of the issuer.

(d) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit a group health plan, or a health insurance issuer in connection with health insurance coverage, from—

(1) distributing any other additional information determined by the plan or issuer to be important or necessary in assisting participants, beneficiaries, and enrollees in the selection of a health plan or health insurance coverage; and

(2) complying with the provisions of this section by providing information in brochures, through the Internet or other electronic media, or through other similar means, so long as—

(A) the disclosure of such information in such form is in accordance with requirements as the appropriate Secretary may impose, and

(B) in connection with any such disclosure of information through the Internet or other electronic media—

(i) the recipient has affirmatively consented to the disclosure of such information in such form,

(ii) the recipient is capable of accessing the information so disclosed on the recipient's individual workstation or at the recipient's home,

(iii) the recipient retains an ongoing right to receive paper disclosure of such information and receives, in advance of any attempt at disclosure of such information to him or her through the Internet or other electronic media, notice in printed form of such ongoing right and of the proper software required to view information so disclosed, and

(iv) the plan administrator appropriately ensures that the intended recipient is receiving the information so disclosed and provides the information in printed form if the information is not received.

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**SA 839.** Mrs. HUTCHISON (for herself and Mrs. CLINTON) submitted an amendment intended to be proposed by her to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

On page 101, between lines 14 and 15, insert the following:

(3) DISENROLLMENT.—Information relating to the disenrollment of a participant, beneficiary, or enrollee.

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**SA 840.** Mr. ENZI proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

On page 172, between lines 15 and 16, insert the following:

**SEC. 304. IMMUNITY FROM LIABILITY FOR PROVISION OF INSURANCE OPTIONS.**

(a) IN GENERAL.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 302, is further amended by adding at the end the following:

''(p) IMMUNITY FROM LIABILITY FOR PROVISION OF INSURANCE OPTIONS.—

''(1) IN GENERAL.—No liability shall arise under subsection (n) with respect to a participant or beneficiary against a group health plan described in paragraph (4) if such plan offers the participant or beneficiary the coverage option described in paragraph (2).

''(2) COVERAGE OPTION.—The coverage option described in this paragraph is one under which the group health plan, at the time of enrollment or as provided for in paragraph (3), provides the participant or beneficiary with the option to—

''(A) enroll for coverage under a fully insured health plan; or

''(B) receive an individual benefit payment, in an amount equal to the amount that would be contributed on behalf of the participant or beneficiary by the plan sponsor for enrollment in the group health plan (as determined by the plan actuary, including factors relating to participant or beneficiary's age and health status), for use by the participant or beneficiary in obtaining health insurance coverage in the individual market.

''(3) TIME OF OFFERING OF OPTION.—The coverage option described in paragraph (2) shall be offered to a participant or beneficiary—

''(A) during the first period in which the individual is eligible to enroll under the group health plan; or

''(B) during any special enrollment period provided by the group health plan after the date of enactment of the Patients' Bill of Rights Plus Act for purposes of offering such coverage option.

''(4) GROUP HEALTH PLAN DESCRIBED.—A group health plan described in this paragraph is a group health plan that is self-insured and self-administered prior to the general effective date described in section 401(a)(1) of the Bipartisan Patient Protection Act.''.

(b) AMENDMENTS TO INTERNAL REVENUE CODE.—

(1) EXCLUSION FROM INCOME.—Section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans) is amended by adding at the end the following:

''(d) TREATMENT OF CERTAIN COVERAGE OPTION UNDER SELF-INSURED PLANS.—No amount shall be included in the gross income of an individual by reason of—

''(1) the individual's right to elect a coverage option described in section 502(o)(2) of the Employee Retirement Income Security Act of 1974, or

''(2) the receipt by the individual of an individual benefit payment described in section 502(o)(2)(A) of such Act.''

(2) NONDISCRIMINATION RULES.—Section 105(h) of such Code (relating to self-insured medical expense reimbursement plans) is amended by adding at the end the following:

''(11) TREATMENT OF CERTAIN COVERAGE OPTIONS.—If a self-insured medical reimbursement plan offers the coverage option described in section 502(o)(2) of the Employee Retirement Income Security Act of 1974, employees who elect such option shall be treated as eligible to benefit under the plan and the plan shall be treated as benefiting such employees.''

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**SA 841.** Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

At the end, add the following:

**SEC. ___. REFUNDABLE TAX CREDITS FOR THE UNINSURED FINANCED WITH CERTAIN CIVIL MONETARY PENALTIES.**

(a) PAYMENT OF CERTAIN PENALTIES TO SECRETARY OF THE TREASURY.—

(1) IN GENERAL.—Notwithstanding any other provision of law, 75 percent of any civil monetary penalty in any proceeding allowed under any provision of, or amendment made by, this Act may only be awarded to the Secretary of the Treasury.

(2) CIVIL MONETARY PENALTY.—For purposes of this section, the term ''civil monetary penalty'' means damages awarded for the purpose of punishment or deterrence, and not solely for compensatory purposes. Such term includes exemplary and punitive damages or any similar damages which function as civil monetary penalties. Such term does not include either economic or non-economic losses. Such term does not include the portion of any award of damages that is not payable to a party or the attorney for a party pursuant to applicable State law.

(b) ESTABLISHMENT OF TRUST FUND.—

(1) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to trust fund code) is amended by adding at the end the following new section:

**''SEC. 9511. HEALTH INSURANCE REFUNDABLE CREDITS TRUST FUND.**

''(a) CREATION OF TRUST FUND.—There is hereby established in the Treasury of the United States a trust fund to be known as the 'Health Insurance Refundable Credits Trust Fund', consisting of such amounts as may be—

''(1) appropriated to such Trust Fund as provided in this section, or

''(2) credited to such Trust Fund as provided in section 9602(b).

''(b) TRANSFER TO TRUST FUND OF AMOUNTS EQUIVALENT TO CERTAIN AWARDS.—There are hereby appropriated to the Health Insurance Refundable Credits Trust Fund amounts equivalent to the awards received by the Secretary of the Treasury under section ____(a) of the Bipartisan Patient Protection Act.

''(c) EXPENDITURES FROM TRUST FUND.—Amounts in the Health Insurance Refundable Credits Trust Fund shall be available to fund the appropriations under paragraph (2) of section 1324(b) of title 31, United States Code, with respect to any refundable tax credit to assist uninsured individuals and families with the purchase of health insurance under this title.''.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter A of chapter 98 of the

Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''9511. Health Insurance Refundable Credits Trust Fund.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

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**SA 842.** Mr. DEWINE submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

On page 171, between lines 14 and 15, insert the following:

**SEC. 303. LIMITATION ON CERTAIN CLASS ACTION LITIGATION.**

(a) ERISA.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 302, is further amended by adding at the end the following:

''(o) LIMITATION ON CLASS ACTION LITIGATION.—

''(1) IN GENERAL.—Any claim or cause of action that is maintained under this section in connection with a group health plan, or health insurance coverage issued in connection with a group health plan, as a class action, derivative action, or as an action on behalf of any group of 2 or more claimants, may be maintained only if the class, the derivative claimant, or the group of claimants is limited to the participants or beneficiaries of a group health plan established by only 1 plan sponsor. No action maintained by such class, such derivative claimant, or such group of claimants may be joined in the same proceeding with any action maintained by another class, derivative claimant, or group of claimants or consolidated for any purpose with any other proceeding. In this paragraph, the terms 'group health plan' and 'health insurance coverage' have the meanings given such terms in section 733.''.

''(2) EFFECTIVE DATE.—This subsection shall apply to all civil actions that are filed on or after January 1, 2002.''.

(b) RICO.—Section 1964(c) of title 18, United States Code, is amended—

(1) by inserting ''(1)'' after the subsection designation; and

(2) by adding at the end the following:

''(2)(A) No private action may be brought under this subsection, or alleging any violation of section 1962, where the action seeks relief concerning the manner in which any person has marketed, provided information concerning, established, administered, or otherwise operated a group health plan, or health insurance coverage in connection with a group health plan. Any such action shall only be brought under the Employee Retirement Income Security Act of 1974. In this paragraph, the terms 'group health plan' and 'health insurance issuer' shall have the meanings given such terms in section 733 of the Employee Retirement Income Security Act of 1974.

''(B) Subparagraph (A) shall apply to private civil actions that are filed on or after January 1, 2002.''.

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**SA 843.** Mr. GRAMM (for himself and Mr. MCCAIN) proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

Insert at the appropriate place:

Notwithstanding any other provision of this act, any exclusion of an exact medical procedure, any exact time limit on the duration or frequency of coverage, and any exact dollar limit on the amount of coverage that is specifically enumerated and defined in the plain language of the plan or coverage documents under the plan or coverage offered by a group health plan or health insurance issuer offering health insurance coverage and that is disclosed under section 121(b)(1) shall be considered to govern the scope of the benefits that may be required, provided that the terms and conditions of the plan or coverage relating to such an exclusion or limit are in compliance with the requirements of law.

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**SA 844.** Mr. SPECTER proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

On page 153, strike line 9 and all that follows through page 154, line 2, and insert the following:

''(10) STATUTORY DAMAGES.—The remedies set forth in this subsection (n) shall be the exclusive remedies for causes of action brought under this subsection. In such actions, the court shall apply the tort laws of the State in determining damages. If such damages are not limited under State law in actions brought under this subsection against a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan), then State law limiting such damages in actions brought against health care entities shall apply until such State enacts legislation imposing such limits against group health plans (and issuers). Nothing in this section shall be construed to require a State to enact legislation imposing limits on damages in actions against group health plans and issuers.

On page 160, between lines 2 and 3, insert the following:

''(D) ACTIONS IN FEDERAL COURT.—A cause of action described in subparagraph (A) shall be brought and maintained only in the Federal district court for the district in the State in which the alleged injury or death that is the subject of such action occurred. In any such action, the court shall apply the laws of such State in determining liability and damages. If such State limits the amount of damages that a plaintiff may receive, such limits shall apply in such actions.

On page 156, strike lines 15 and 16 and insert the following:

subsection.

''(o) LIMITATION ON CLASS ACTION LITIGATION.—

''(1) LIMITATION.—

''(A) IN GENERAL.—Any claim or cause of action that is maintained under this section in connection with a group health plan, or health insurance coverage issued in connection with a group health plan, as a class action, derivative action, or as an action on behalf of any group of 2 or more claimants, may be maintained only if the class, the derivative action claimant, or the group of claimants is limited to the participants, beneficiaries, or enrollees with respect to a group health plan established by only 1 plan sponsor or with respect to coverage provided by only 1 issuer. No action maintained by such class, such derivative action claimant, or such group of claimants may be joined in the same proceeding with any action maintained by another class, derivative action claimant, or group of claimants or consolidated for any purpose with any other proceeding.

''(B) DEFINITIONS.—In this paragraph, the terms 'group health plan' and 'health insurance coverage' have the meanings given such terms in section 733.

''(2) EFFECTIVE DATE.—Paragraph (1) shall apply to all actions that are pending and have not been finally determined by judgment or settlement prior to the date of enactment of the Bipartisan Patient Protection Act, and all actions that are filed not earlier than that date.''.

(2) RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT.—Section 1964(c) of title 18, United States Code, is amended—

(A) by inserting ''(1)'' after the subsection designation; and

(B) by adding at the end the following:

''(2)(A)(i) No action may be brought under this subsection, or alleging any violation of section 1962, if the action seeks relief concerning the manner in which any person has marketed, provided information concerning, established, administered, or otherwise operated or provided a group health plan, or health insurance coverage issued in connection with a group health plan. Any such action shall only be brought under the Employee Retirement Income Security Act of 1974.

''(ii) In this subparagraph, the terms 'group health plan' and 'health insurance issuer' have the meanings given such terms in section 733 of the Employee Retirement Income Security Act of 1974.

''(B) Subparagraph (A) shall apply to actions that are pending and have not been finally determined by judgment or settlement prior to the date of enactment of the Bipartisan Patient Protection Act, and all actions that are filed not earlier than that date.''.

(3) CONFORMING AMENDMENT.—Section

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**SA 845.** Mr. GRASSLEY proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

On page 179, strike lines 1 through 14.

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**SA 846.** Mr. NICKLES (for himself and Mr. ENSIGN) proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

Beginning on page 173, strike line 19 and all that follows through line 14 on page 174, and insert the following:

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—The amendments made by sections 201(a), 301, 302, and 303 (and title I insofar as it relates to such sections) shall apply to group health plans maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers beginning on the general effective date.

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**SA 847.** Mr. BROWNBACK proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

At the end of the bill, add the following:

**TITLE —HUMAN—GERMLINE GENE MODIFICATION**

**SEC. 01. SHORT TITLE.**

This title may be cited as the ''Human Germline Gene Modification Prohibition Act of 2001''.

**SEC. 02. FINDINGS.**

Congress makes the following findings:

(1) Human Germline gene modification is not needed to save lives, or alleviate suffering, of existing people. Its target population is ''prospective people'' who have not been conceived.

(2) The cultural impact of treating humans as biologically perfectible artifacts would be entirely negative. People who fall short of some technically achievable ideal would be seen as ''damaged goods'', while the standards for what is genetically desirable will be those of the society's economically and politically dominant groups. This will only increase prejudices and discrimination in a society where too many such prejudices already exist.

(3) There is no way to be accountable to those in future generations who are harmed or stigmatized by wrongful or unsuccessful human germline modifications of themselves or their ancestors.

(4) The negative effects of human germline manipulation would not be fully known for generations, if ever, meaning that countless people will have been exposed to harm probably often fatal as the result of only a few instances of germline manipulations.

(5) All people have the right to have been conceived, gestated, and born without genetic manipulation.

**SEC. 03. PROHIBITION ON HUMAN GERMLINE GENE MODIFICATION**

(a) IN GENERAL.—Title 18, United States Code, is amended by inserting after chapter 15, the following:

''Chapter 16—Germline Gene Modification

''Sec.
''301. Definitions
''302. Prohibition on germline gene modification.

**''§ 301. Definitions**

''In this chapter:

(1) HUMAN GERMLINE GENE MODIFICATION.—The term 'human germline modification' means the intentional modification of DNA in any human cell (including human eggs, sperm, fertilized eggs, zygotes, blastocysts, embryos, or any precursor cells that will differentiate into gametes or can be manipulated to do so) for the purpose of producing a genetic change which can be passed on to future individuals, including inserting, deleting or altering DNA from any source, and in any form, such as nuclei, chromosomes, nuclear, mitochondrial, and synthetic DNA. The term does not include any modification of cells that are not a part of and will not be used to create human embryos. Nor does it include the change of DNA involved in the normal process of sexual reproduction.

''(2) HUMAN HAPLOID CELL.—The term 'haploid cell' means a cell that contains only a single copy of each of the human chromosomes, such as eggs, sperm, and their precursors.

''(3) SOMATIC CELL.—The term 'somatic cell' means a diploid cell (having two sets of the chromosomes of almost all body cells) obtained or derived from a living or deceased human body at any stage of development. Somatic cells are diploid cells that are not precursors of either eggs or sperm. A genetic modification of somatic cells is therefore not germline genetic modification.

Rule of construction: Nothing in this Act is intended to limit somatic cell gene therapy, or to effect research involving human pluripotent stem cells.

**''§ 302. Prohibition on germline gene modification**

''(a) IN GENERAL.—It shall be unlawful for any person or entity, public or private, in or affecting interstate commerce—

''(1) to perform or attempt to perform human germline gene modification;

''(2) to intentionally participate in an attempt to perform human germline gene modification; or

''(3) to ship or receive the product of human germline gene modification for any purpose.

''(b) IMPORTATION.—It shall be unlawful for any person or entity, public or private, to import the product of human germline gene modification for any purpose.

''(c) PENALTIES.—

''(1) In general.—Any person or entity that is convicted of violating any provision of this section shall be fined under this section or imprisoned not more than 10 years, or both.

''(2) CIVIL PENALTY.—Any person or entity that is convicted of violating any provision of this section shall be subject to, in the case of a violation that involves the derivation of a pecuniary gain, a civil penalty of not less than $1,000,000 and not more than an amount equal to the amount of the gross gain multiplied by 2, if that amount is greater than $1,000,000.

''(b) CLERICAL AMENDMENT.—The table of chapters for part I of title 18, United States Code, is amended by inserting after the item relating to chapter 15 the following:

''16. Germline Gene Modification ..... 301''.

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**SA 848.** Mr. ENSIGN proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

At the end, add the following:

**SEC. ___. IMMUNITY.**

(a) IN GENERAL.—Notwithstanding any other provision of law, no health care professional shall be liable for the performance of, or the failure to perform, any duty in providing pro bono medical services to a medically underserved or indigent individual.

(b) DEFINITIONS.—In this section:

(1) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' has the meaning given the term in section 151.

(2) MEDICALLY UNDERSERVED OR INDIGENT INDIVIDUAL.—The term ''medically underserved or indigent individual'' means an individual that does not have health care coverage under a group health plan, health insurance coverage, or any other health care coverage program, or who is unable to pay for the health care services that are provided to the individual.

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**SA 849.** Mr. ENSIGN proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

Subtitle C of title I is amended by adding at the end the following:

**SEC. 122. GENETIC INFORMATION.**

(a) DEFINITIONS.—In this section:

(1) CONTROLLED GROUP.—The term ''controlled group'' means any group treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986.

(2) FAMILY MEMBER.—The term ''family member'' means with respect to an individual—

(A) the spouse of the individual;

(B) a dependent child of the individual, including a child who is born to or placed for adoption with the individual; and

(C) all other individuals related by blood to the individual or the spouse or child described in subparagraph (A) or (B).

(3) GENETIC INFORMATION.—The term ''genetic information'' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member of such individual (including information about a request for or the receipt of genetic services by such individual or a family member of such individual).

(4) GENETIC SERVICES.—The term ''genetic services'' means health services, including genetic tests, provided to obtain, assess, or interpret genetic information for diagnostic and therapeutic purposes, and for genetic education and counseling.

(5) GENETIC TEST.—The term ''genetic test'' means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites in order to detect genotypes, mutations, or chromosomal changes.

(6) GROUP HEALTH PLAN, HEALTH INSURANCE ISSUER.—The terms ''group health plan'' and ''health insurance issuer'' include a third party administrator or other person acting for or on behalf of such plan or issuer.

(7) PREDICTIVE GENETIC INFORMATION.—

(A) IN GENERAL.—The term ''predictive genetic information'' means—

(i) information about an individual's genetic tests;

(ii) information about genetic tests of family members of the individual; or

(iii) information about the occurrence of a disease or disorder in family members.

(B) LIMITATIONS.—The term ''predictive genetic information'' shall not include—

(i) information about the sex or age of the individual;

(ii) information about chemical, blood, or urine analyses of the individual, unless these analyses are genetic tests; or

(iii) information about physical exams of the individual, and other information relevant to determining the current health status of the individual.

(b) NONDISCRIMINATION.—

(1) NO ENROLLMENT RESTRICTION FOR GENETIC SERVICES.—A group health plan, and a health insurance issuer offering health insurance coverage, shall not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on genetic information (or information about a request for or the receipt of genetic services by such individual or a family member of such individual) in relation to the individual or a dependent of the individual.

(2) NO DISCRIMINATION IN GROUP RATE BASED ON PREDICTIVE GENETIC INFORMATION.—A group health plan, and a health insurance issuer offering health insurance coverage, shall not deny eligibility to a group or adjust premium or contribution rates for a group on the basis of predictive genetic information concerning an individual in the group (or information about a request for or the receipt of genetic services by such individual or a family member of such individual).

(3) LIMITATION ON GENETIC TESTING.—

(A) LIMITATION ON REQUESTING OR REQUIRING GENETIC TESTING.—A group health plan, or a health insurance issuer offering health insurance coverage, shall not request or require an individual or a family member of such individual to undergo a genetic test.

(B) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit the authority of a health care professional, who is providing treatment with respect to an individual and who is employed by a group health plan or a health insurance issuer, to request that such individual or family member of such individual undergo a genetic test. Such a health care professional shall not require that such individual or family member undergo a genetic test.

(4) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—Except as provided in subsections (c) and (d), a group health plan, or a health insurance issuer offering health insurance coverage, shall not request, require, collect, or purchase predictive genetic information concerning an individual (or information about a request for or the receipt of genetic services by such individual or a family member of such individual).

(5) DISCLOSURE OF PREDICTIVE GENETIC INFORMATION.—A group health plan, or a health insurance issuer offering health insurance coverage, shall not disclose predictive genetic information about an individual (or information about a request for or the receipt of genetic services by such individual or a family member of such individual) to—

(A) any entity that is a member of the same controlled group as such issuer or plan sponsor of such group health plan;

(B) any other group health plan or health insurance issuer or any insurance agent, third party administrator, or other person subject to regulation under State insurance laws;

(C) the Medical Information Bureau or any other person that collects, compiles, publishes, or otherwise disseminates insurance information;

(D) the individual's employer or any plan sponsor; or

(E) any other person the Secretary may specify in regulations.

(c) INFORMATION FOR PAYMENT FOR GENETIC SERVICES.—

(1) IN GENERAL.—With respect to payment for genetic services conducted concerning an individual or the coordination of benefits, a group health plan, or a health insurance issuer offering health insurance coverage, may request that the individual provide the plan or issuer with evidence that such services were performed.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) shall be construed to—

(A) permit a group health plan or health insurance issuer to request (or require) the results of the services referred to in such paragraph; or

(B) require that a group health plan or health insurance issuer make payment for services described in such paragraph where the individual involved has refused to provide evidence of the performance of such services pursuant to a request by the plan or issuer in accordance with such paragraph.

(d) INFORMATION FOR PAYMENT OF OTHER CLAIMS.—With respect to the payment of claims for benefits other than genetic services, a group health plan, or a health insurance issuer offering health insurance coverage, may request that an individual provide predictive genetic information so long as such information—

(1) is used solely for the payment of a claim;

(2) is limited to information that is directly related to and necessary for the payment of such claim and the claim would otherwise be denied but for the predictive genetic information; and

(3) is used only by an individual (or individuals) within such plan or issuer who needs access to such information for purposes of payment of a claim.

(e) RULES OF CONSTRUCTION.—

(1) COLLECTION OR DISCLOSURE AUTHORIZED BY INDIVIDUAL.—The provisions of paragraphs (4) (regarding collection) and (5) of subsection (b) shall not apply to an individual if the individual (or legal representative of the individual) provides prior, knowing, voluntary, and written authorization for the collection or disclosure of predictive genetic information.

(2) DISCLOSURE FOR HEALTH CARE TREATMENT.—Nothing in this section shall be construed to limit or restrict the disclosure of predictive genetic information from a health care provider to another health care provider for the purpose of providing health care treatment to the individual involved.

(f) VIOLATION OF GENETIC DISCRIMINATION OR GENETIC DISCLOSURE PROVISIONS.—

(1) IN GENERAL.—In any action under a covered provision against any administrator of a group health plan, or health insurance issuer offering health insurance coverage (including any third party administrator or other person acting for or on behalf of such plan or issuer) alleging a violation of subsection (b), (c), or (d), the court may award any appropriate legal or equitable relief. Such relief may include a requirement for the payment of attorney's fees and costs, including the costs of expert witnesses.

(2) DEFINITION.—In this subsection, the term ''covered provision'' means section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) or section 2722 or 2761 of the Public Health Service Act (42 U.S.C. 300gg–2, 300gg–61).

(g) CIVIL PENALTY.—The monetary provisions of section 308(b)(2)(C) of Public Law 101–336 (42 U.S.C. 12188(b)(2)(C)) shall apply for purposes of the Secretary enforcing the provisions referred to in subsection (f), except that any such relief awarded shall be paid only into the general fund of the Treasury.

(h) SPECIAL RULE IN CASE OF GENETIC INFORMATION.—With respect to health insurance coverage offered by a health insurance issuer, the provisions of this section relating to genetic information (including information about a request for or the receipt of genetic services by an individual or a family member of such individual) shall not be construed to supersede any provision of State law that establishes, implements, or continues in effect a standard, requirement, or remedy that more completely—

(1) protects the confidentiality of genetic information (including information about a request for or the receipt of genetic services by an individual or a family member of such individual) or the privacy of an individual or a family member of the individual with respect to genetic information (including information about a request for or the receipt of genetic services by the individual or a family member of such individual); or

(2) prohibits discrimination on the basis of genetic information than does this section.

At the end of title II, insert the following:

**SEC. 203. ELIMINATION OF OPTION OF NON-FEDERAL GOVERNMENTAL PLANS TO BE EXCEPTED FROM REQUIREMENTS CONCERNING GENETIC INFORMATION.**

Section 2721(b)(2) of the Public Health Service Act (42 U.S. C. 300gg–21(b)(2)) is amended—

(1) in subparagraph (A), by striking ''If the plan sponsor'' and inserting ''Except as provided in subparagraph (D), if the plan sponsor''; and

(2) by adding at the end the following:

''(D) ELECTION NOT APPLICABLE TO REQUIREMENTS CONCERNING GENETIC INFORMATION.—The election described in subparagraph (A) shall not be available with respect to the provisions of subsections (b), (c), and (d) of section 122 of the Bipartisan Patient Protection Act and the provisions of section 2702(b) to the extent that the subsections and section apply to genetic information (or information about a request for or the receipt of genetic services by an individual or a family member of such individual).''.

**SEC. 204. APPLICATION OF GENETIC NONDISCRIMINATION REQUIREMENTS TO MEDIGAP PLANS.**

(a) NONDISCRIMINATION.—Section 1882(s)(2) of the Social Security Act (42 U.S.C. 1395ss(s)(2)) is amended by adding at the end the following:

''(E) Each issuer of a medicare supplemental policy, and each such policy offered by such an issuer, shall comply with the requirements under section 122 of the Bipartisan Patient Protection Act.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to each issuer of a medicare supplemental policy and each such policy for policy years beginning after October 1, 2002.

(c) TRANSITION PROVISIONS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the amendment made by subsection (a), the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act (42 U.S.C. 1395ss) due solely to failure to make such change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, not later than June 30, 2002, the National Association of Insurance Commissioners (in this subsection referred to as the ''NAIC'') modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act (referred to in such section as the 1991 NAIC Model Regulation, as subsequently modified) to conform to the amendment made by subsection (a), such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall, not later than October 1, 2002, make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate regulation for the purposes of such section.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section; or

(ii) October 1, 2002.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the amendment made by subsection (a); but

(ii) having a legislature which is not scheduled to meet in 2002 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 2002. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

**SEC. 205. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE INTERNAL REVENUE CODE OF 1986.**

(a) IN GENERAL.—Chapter 100 of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subchapter C as subchapter D; and

(2) by inserting after subchapter B the following:

**''SUBCHAPTER C—PATIENT PROTECTION STANDARDS**

**''SEC. 9821. PATIENT PROTECTION STANDARDS.**

''Each group health plan shall comply with patient protection requirements under title I of the Bipartisan Patient Protection Act, and each health insurance issuer shall comply with patient protection requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this section.''.

(b) APPLICATION TO EMPLOYERS WITH FEWER THAN 2 EMPLOYEES.—Section 9831(a) of the Internal Revenue Code of 1986 is amended by striking ''this chapter'' and inserting ''this chapter (other than section 9821, with respect to the application of section 122 of the Bipartisan Patient Protection Act)''.

After section 301, insert the following:

**SEC. 301A. APPLICATION TO EMPLOYERS WITH FEWER THAN 2 EMPLOYEES.**

Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191a(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 714(a) (with respect to the application of section 122 of the Bipartisan Patient Protection Act)''.

## AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON AGRICULTURAL, NUTRITION, AND FORESTRY

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Agriculture, Nutrition, and Forestry be authorized to meet during the session of the Senate on Thursday, June 28, 2001. The purpose of this hearing will be to discuss the next Federal farm bill.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ARMED SERVICES

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on Thursday, June 28, 2001, at 2:30 p.m., in open session to receive testimony on the fiscal year 2002 budget amendment, in review of the Defense authorization request for fiscal year 2002 and the Future Years Defense Program.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during these session of the Senate on June 28, 2001, to conduct a hearing on ''The Reauthorization of the Iran and Libya Sanctions Act.''

THE PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate on Thursday, June 28 at 9:30 a.m. to conduct an oversight hearing. The committee will receive testimony on science and technology studies on climate change.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Thursday, June 28, 2001, at 2 p.m. to hold a hearing titled, ''Zimbabwe's Political and Economic Crisis'' as follows:

WITNESSES

Panel 1: Walter H. Kansteiner, Assistant Secretary of State for African Affairs, Department of State, Washington, DC.

Panel 2: Professor Robert Rotberg, President, World Peace Foundation, Cambridge, MA.

Yves Sorokobi, Africa Director, Committee to Protect Journalists, New York, NY.

Mr. John Prendergast, International Crisis Group, Washington, DC.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Governmental Affairs be authorized to meet Thursday, June 28, 2001, at 9:30 am for a hearing regarding ''The Impact of Electric Industry Restructuring on System Reliability.''

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON RULES AND ADMINISTRATION

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Rules and Administration be authorized to meet during the session of the Senate on Thursday, June 28, 2001, at 10 a.m., to receive testimony from Members of the House of Representatives on election reform.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON VETERANS' AFFAIRS

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Veterans' Affairs be authorized to meet during the session of the Senate on Thursday, June 28, 2001, at 10 a.m., in room 418 of the Russell Senate Office Building, for a hearing on pending veterans' benefits legislation as follows:

S. 1090: Cost-of-living adjustment for veterans' benefits. Sponsor: Senator ROCKEFELLER.

S. 1089: U.S. Court of Appeals for Veterans Claims (CAVC) succession plan to address judges retiring in 2004/2005. Repeals the NOD as a jurisdictional threshold for appearing before the CAVC. Sponsor: Senator ROCKEFELLER.

S. 1091: (1) Eliminates the 30-year limit on manifestation from time of exposure for the presumption of service connection for Agent Orange-related respiratory cancer; (2) Restores a VA presumption, eliminated by a Court decision, that in-country Vietnam veterans were exposed to Agent Orange; (3) tasks the National Academy of Sciences to continue reporting on Agent Orange and its association with disease for 10 more years (5 reports). Sponsor: Senator ROCKEFELLER.

S. 1063: CAVC-requested bill pertaining to administrative matters. Sponsor: Senator ROCKEFELLER.

S. 1088. Creates flexibility for MGIB to pay for high tech/short-term courses. Sponsor: Senator ROCKEFELLER.

S. 1093: Miscellaneous veterans' benefits provisions (based on informal input from VA):

COMPENSATION

a. Eliminate compensation for incarcerated persons—We previously enacted legislation to reduce compensation to incarcerated veterans to the equivalent of 10 percent, disability compensation (or, if they only received 10 percent, to the equivalent of 5 percent). Veterans that were already incarcerated were grandfathered out of the reduction. This change would stop only future payments to these veterans.

b. Reduce benefits for fugitive felons—Currently, veterans who are fugitive from justice are eligible to receive VA benefits. This would bar them from receiving benefits while a fugitive (fleeing prosecution, confinement for a felony, or in violation of a condition of probation or parole).

c. Duty to assist (technical corrections).

VOCATIONAL REHABILITATION

Eliminate the cap of 500 veteran participants in Voc Rehab's ''Independent Living'' program. The cap was set when the program was initially piloted. While the time limit on the program was repealed, the cap on participants was not. VA has not turned any one away from the program, but has been exceeding 500 veterans in the last couple of years. The goal of the program is to assist a veteran who is too disabled to retrain for employment to achieve and maintain a stated independent living outcome.

LOAN GUARANTY

Increase the home loan guaranty amount to $63,175 from the current $50,750, to keep pace with FHA (and the even higher Fannie Mae or Freddie Mac). The VA amount has not been increased since 1994.

EDUCATION

Overturn court decision eliminating the delimiting date for use of chapter 35 educational benefits by surviving spouses. The spouse would be allowed to choose the beginning date of the eligibility period. It could be any date between the effective date of the rating of the veteran's service-connected disability as permanently and totally disabling, and the date VA notified the veteran of this fact. A 10-year period would run from the date the spouse chose.

PENSION

a. Excludes life insurance proceeds from countable income for determination of nonservice-connected death pension eligibility for poor surviving spouses of wartime veterans. Currently, counting life insurance could make the spouse ineligible for a year. Modifies effective date of beginning benefits.

b. Modifies the requirement for pensioners to report changes in income at the end of the month, to the end of the year.

S. 131: To increase the rate of the basic benefit of MGIB to the average cost of tuition next fiscal year, and then modify the annual COLA to be pegged to educational inflation. Sponsor: Senator JOHNSON.

S. 228: To make permanent the Native American veterans housing loan

program. The program is set to expire in 2002. Sponsor: Senator AKAKA.

S. 409: To clarify the standards for compensation for Persian Gulf veterans suffering from certain undiagnosed illnesses and to extend Persian Gulf compensation presumption. Sponsor: Senator HUTCHISON.

S. 457: To establish a presumption of service connection for certain veterans with hepatitis C. Sponsor: Senator SNOWE.

S. 662: To authorize the Secretary of Veterans Affairs to furnish headstones or markers for marked graces of, or to otherwise commemorate, certain individuals if buried after November 1, 1990. Sponsor: Senator DODD.

S. 781: To extend the authority for housing loan guaranties for members of the Selected Reserve now set to expire in 2007. Sponsor: Senator AKAKA.

S. 912: To increase burial benefits for veterans from $300 to $1,135 and from $1,500 to $3,713, and plot allowances from $150 to $670. Also, to index future increases to the CPI. Sponsor: Senator MIKULSKI.

S. 937: To permit the relevant Secretary to transfer entitlement to MGIB educational assistance from members of the Armed Forces to their dependents for up to 18 months of benefits, and allow them to receive the payment as an accelerated payment for a term/semester (solely upon the discretion of the Secretary). Sponsor: Senator CLELAND.

The PRESIDING OFFICER. Without objection, it is so ordered.

SPECIAL COMMITTEE ON AGING

Mr. REID. Mr. President, I ask unanimous consent that the Special Committee on Aging be authorized to meet on Thursday, June 28, 2001, from 10 a.m.–12 p.m. in Dirksen 226 for the purpose of conducting a hearing.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON SURFACE TRANSPORTATION AND MERCHANT MARINE

Mr. REID. Mr. President, I ask unanimous consent that the Subcommittee on Surface Transportation and Merchant Marine of the Committee on Commerce, Science, and Transportation be authorized to meet on June 28, 2001, at 2:30 p.m., on Surface Transportation Board Rail Merger Rules.

The PRESIDING OFFICER. Without objection, it is so ordered.

## UNANIMOUS CONSENT AGREEMENT—S. 1077

Mr. REID. Mr. President, I ask unanimous consent that at 1 p.m., Monday, July 9, the Senate proceed to the consideration of Calendar No. 76, S. 1077, the supplemental appropriations bill; that the bill be considered under the following limitations: that the only first-degree amendments in order other than a managers' amendment be the following list which is at the desk; that all listed amendments must be offered by 6 p.m. Monday, July 9, with the exception of the managers' amendment; that the managers or designees be authorized to offer any listed first-degree amendment in order for that amendment to qualify under the deadline; that any listed first-degree amendment be subject to relevant second-degree amendments; that any time limitation for debate on a first-degree amendment specified in this agreement then a second-degree amendment to that amendment would be accorded the same time limit; further, that upon disposition of the above amendments, the bill be advanced to third reading and the Senate then proceed to the consideration of Calendar No. 77, H.R. 2216; that all after the enacting clause be stricken and the text of S. 1077, as amended, be inserted in lieu thereof; that the bill be advanced to third reading and the Senate then vote on passage of the bill, with no intervening action or debate; finally, I ask unanimous consent that S. 1077 be returned to the calendar.

The PRESIDING OFFICER. Without objection, it is so ordered.

The list of amendments is as follows:

Biden amendment re: Relevant,
Bond amendment re: Department of Defense,
Bond amendment re: Corp of Engineers,
Boxer amendment re: Sudden Oak Death,
Boxer amendment re: Path 15,
Byrd amendment re: Relevant,
Byrd amendment re: Relevant to any on list,
Cleland amendment re: B–1 bomber transportation,
Conrad amendment re: Turtle Mountain Indian Reservation,
Conrad amendment re: Devil's Lake,
Conrad amendment re: Relevant,
Craig amendment re: Relevant,
Daschle amendment re: Relevant,
Daschle amendment re: Relevant to any on list,
Feingold amendment re: Relevant,
Feingold amendment re: Klamath Basin,
Feinstein amendment re: Klamath Basin,
Hutchinson (AR) amendment re: AR ice storms,
Inouye amendment re: Relevant,
Johnson amendment re: Relevant,
Lott amendment re: Relevant,
Lott amendment re: Relevant to any on list,
McCain amendment re: Defense,
McCain amendment re: Dept. of Defense with a time limit of 2 hours equally divided and controlled,
Nickles amendment re: Relevant,
Miller amendment re: B–1 bomber transportation,
Reid (NV) amendment re: Relevant,
Reid (NV) amendment re: Relevant to any on list,
Roberts amendment re: B–1 bombers,
Schumer amendment re: IRS,
Schumer amendment re: Relevant,
(4) Smith (OR) amendment re: Klamath Falls,
Stevens amendment re: Relevant,
Stevens amendment re: Relevant to any on list,
Voinovich amendment re: Social Security Lock Box,
Warner amendment re: Building naming,
Wellstone amendment re: LIHEAP.

## ORDERS FOR FRIDAY, JUNE 29, 2001

Mr. REID. Mr. President, I ask unanimous consent that when the Senate completes its business tonight, it adjourn until the hour of 9 a.m. tomorrow, Friday, June 29. I further ask consent that on Friday, immediately following the prayer and the pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of the Patients' Bill of Rights.

The PRESIDING OFFICER. Without objection, it is so ordered.

## PROGRAM

Mr. REID. Mr. President, on behalf of Senator DASCHLE, I announce that tomorrow we will convene at 9 a.m. and that shortly thereafter, as soon as the prayer and pledge are completed, we will resume consideration of the Patients' Bill of Rights, with the votes as outlined previously in the unanimous consent request.

## ADJOURNMENT UNTIL 9 A.M. TOMORROW

Mr. REID. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment under the previous order.

There being no objection, the Senate, at 10:30 p.m., adjourned until Friday, June 29, 2001, at 9 a.m.

## NOMINATIONS

Executive nominations received by the Senate June 28, 2001:

DEPARTMENT OF COMMERCE

LINDA MYSLIWY CONLIN, OF NEW JERSEY, TO BE AN ASSISTANT SECRETARY OF COMMERCE, VICE MICHAEL J. COPPS, RESIGNED.

DEPARTMENT OF ENERGY

DAN R. BROUILLETTE, OF LOUISIANA, TO BE AN ASSISTANT SECRETARY OF ENERGY (CONGRESSIONAL AND INTERGOVERNMENTAL AFFAIRS), VICE JOHN C. ANGELL, RESIGNED.

ENVIRONMENTAL PROTECTION AGENCY

DONALD R. SCHREGARDUS, OF OHIO, TO BE AN ASSISTANT ADMINISTRATOR OF THE ENVIRONMENTAL PROTECTION AGENCY, VICE STEVEN ALAN HERMAN, RESIGNED.

DEPARTMENT OF STATE

STUART A. BERNSTEIN, OF THE DISTRICT OF COLUMBIA, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO DENMARK.

CHARLES A. HEIMBOLD, JR., OF CONNECTICUT, TO BE AMBASSADOR EXTRAORDINARY AND PLENIPOTENTIARY OF THE UNITED STATES OF AMERICA TO SWEDEN.

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

CAROLE BROOKINS, OF INDIANA, TO BE UNITED STATES EXECUTIVE DIRECTOR OF THE INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT FOR A TERM OF TWO YEARS, VICE JAN PIERCY, TERM EXPIRED.

DEPARTMENT OF DEFENSE

H. T. JOHNSON, OF VIRGINIA, TO BE AN ASSISTANT SECRETARY OF THE NAVY, VICE ROBERT B. PIRIE, JR., RESIGNED.

IN THE AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

*To be lieutenant general*

LT. GEN. PAUL V. HESTER, 0000

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

*To be lieutenant general*

MAJ. GEN. LANCE L. SMITH, 0000

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

*To be lieutenant general*

MAJ. GEN. THOMAS C. WASKOW, 0000